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PART 2, SECTION VI: Developing Work Plans With Timeframes And Budgets/ Staffing Projections

Sub-section II: Programs to be Developed or Expanded—the following information is required for each program. Since the review process may approve individual program work plans separately, it is critical that a complete description is provided for each program. If a particular question is not applicable for the proposed program, please so indicate.

FULL SERVICE PARTNERSHIPS FOR ALL AGE GROUPS

Programs proposed by the Los Angeles County Plan:

- **C-01: Children's Full Service Partnership**
- **T-01: Transition Age Youth's Full Service Partnership**
- **A-01: Adult's Full Service Partnership**
- **OA-01: Older Adult's Full Service Partnership**

1) Complete Exhibit 4 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1a - 1d. Questions 2 – 13 are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The August 1, 2005 guidelines issued by the State Department of Mental Health contain the following description of Full Service Partnerships:

> Each individual identified as part of the initial full service population must be offered a partnership with the county mental health program to develop an individualized services and supports plan. The services and supports plans must operationalize the five fundamental concepts identified at the beginning of this document. They must reflect community collaboration, they must be culturally competent, they must be client/family driven with a wellness/recovery/resiliency focus and they must provide an integrated service experience for the client/family. Under Full Service Partnerships:
>
> - The county agrees to work with the individual and his/her family, as appropriate, to provide all necessary and desired appropriate services and supports in order to assist that person/family in achieving the goals identified in their plan.
> - Individuals will have an individualized service plan that is person/child-centered, and individuals and their families will be given

sufficient information to allow them to make informed choices about the services in which they participate.

- All fully served individuals will have a single point of responsibility – Personal Service Coordinators (PSCs) for adults – case managers for children and youth – with a caseload that is low enough so that: (1) their availability to the individual and family is appropriate to their service needs, (2) they are able to provide intensive services and supports when needed, and (3) they can give the individual served and/or family member considerable personal attention. Services must include the ability of PSCs, children's case managers or team members known to the client or family member to respond to clients and family members 24 hours a day, 7 days a week. This 'best practice' service strategy is intended to provide immediate 'after-hours' interventions that will reduce negative outcomes for individuals including but not limited to unnecessary hospitalizations, incarcerations and evictions. For transition age youth, adults and older adults this service must include the ability to respond to landlords and or law enforcement. For children and youth it must include the ability to respond to persons in the community identified by a child's family.
- PSCs/case managers must be culturally competent, and know the community resources of the client's racial ethnic community.
- Services should also include linkage to, or provision of, all needed services or benefits as defined by the client and or family in consultation with the PSC/case manager. This includes the capability of increasing or decreasing service intensity as needed. Community Support Services, consistent with the individual service plan may only be funded by MHSA funds when funding under any other public or private payor source or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services pursuant to Medi-Cal and Special Education Programs. (State CSS Guidelines, pp. 22-23)

Los Angeles County fully embraces this description of Full Service Partnerships as the overarching framework for the development of these initiatives for each of the four target age groups. What follows is a more specific analysis of Full Service Partnerships by each of the four target age groups.

CHILDREN 0-15

1. Recommended Target Populations for Full Service Partnerships

In the August 1, 2005 guidelines the State Department of Mental Health recommends several groups of children aged 0-18 as candidates for target populations. These

groups include children and youth between the ages of 0 and 18, [1] or Special Education students through the end of the school year in which they turn 22 and their families, who have serious emotional disorders and who are not currently being served. This population generally consists of:

- Youth and their families who are uninsured, under-insured and/or youth who are not eligible for Medi-Cal because they are detained in the juvenile justice system;
- Homeless youth, youth in foster care placed out-of-county and youth with multiple (more than two) foster care placements;
- Children and youth who are so underserved that they are at risk of homelessness or out-of-home placement. (State CSS Guidelines, p. 21)

Stakeholder delegates embraced the State's recommended focal populations, though many of the sub-groups specified by the State actually fall within the focal populations identified by the Transition Age Youth (TAY) workgroup (see the TAY discussion in the next section). The delegates further defined the recommended focal populations to include children (0 to 15) with severe emotional disorders [SED] and their families, with a priority placed on children with co-occurring disorders, recent hospitalizations, psychotic disorders, or showing symptoms of trauma experiences. In particular we will focus on:

- Pre-natal to 5 year olds who are at high risk of being expelled from pre-school, involved with or at high risk of being detained by the Department of Children and Family Services (DCFS); or children of parents or caregivers who have SED or severe and persistent mental illness, or have a co-occurring substance abuse disorder;
- Children who have been removed from their homes or who are at high risk of being removed from their home by DCFS, and who are in transition to less restrictive placements;
- Children who are experiencing the following at school:
  - Expulsion or suspension, or high risk of either;
  - Violent behaviors;
  - Drug possession or use;
  - Suicidal and/or homicidal ideation; and/or
  - Truancy; and
- Youth involved with the Probation Department who are being treated with psychotropic medications and who are transitioning back into less structured home and community settings.

[1] The first draft of the CSS guidelines issued by the State set the age range for children at 0-15. In subsequent versions of the guidelines, including the final guidelines, the State established the age range for children at 0-18, creating an overlap with Transition Age Youth. We have opted to keep the age range for children at 0-15, and to create ad hoc structures for the Children and Transition Age Youth workgroups to work together when they are addressing issues that cross between the two populations.

2. Recommended Outcomes

Delegates have embraced the outcomes for children and their families as specified by the State's August 1, 2005 guidelines, including:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including during times of crisis;
- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

Delegates also embraced the additional outcome of maintaining or improving physical health, as it relates to the achievement of the other outcomes, for children and their families.

3. Recommendations for Full Service Partnership Programs for Children

Delegates embraced the definition of Full Service Partnerships as outlined above. Delegates also embraced a range of other criteria for Full Service Partnerships for this age group, including:

- Culturally competent services;
- Services provided in the home, school, and community;
- Strength based assessments;
- Services provided to family members when essential for the achievement of outcomes for the child;
- Benefit establishment services;
- Mental health treatment for parents of SED children who may not meet the target population definition in the adult system;
- Evidence based treatment practices; and
- Parent Advocacy

TRANSITION AGE YOUTH 16-25

1. Recommended Target Populations for Full Service Partnerships

On August 1, 2005, State Department of Mental Health guidelines recommended several groups of Transition Age Youth 16-25 as candidates for target populations.

These groups include transition age youth between the ages of 16 and 25, who are currently unserved or underserved who have serious emotional disorders and who are:

- Homeless or at imminent risk of being homeless;
- Youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems;
- Youth involved in the criminal justice system or at risk of involuntary hospitalization or institutionalization; and
- Transition age youth who have experienced a first episode of major mental illness. (State CSS Guidelines, p. 21)

The delegates have embraced the State's recommended focal populations, and further refined them in the following manner. The delegates intend to make a long-term commitment to all transition age youth 16-25 who have severe emotional disturbances (SED) or Severe Mental Illnesses (SMI) that result in significant functional impairment, or who demonstrate significant social, emotional, educational and/or occupational impairments who could meet the criteria for an SED and/or SMI diagnosis, including those youth with dual diagnoses or co-occurring disorders, including substance abuse disorders and others.

However, during the first three years of the CSS Plan, focus will be on those youth who are unserved, underserved or inappropriately served, including those who are homeless, or at risk of homelessness, and/or youth aging out of the children's mental health, child welfare, and juvenile justice systems.

In particular, we will give priority to youth who:

- Have been in or are leaving long term institutional settings—e.g., level 14 group homes—including those youth who, though diagnostically qualified for level 14 group homes, were living in other settings;
- Have been in hospitals, Institutes for Mental Disease (IMDs), Community Treatment Facilities, jails, and/or probation camps; and
- Youth who have experienced their first psychotic break.

2. Recommended Outcomes

Delegates have embraced the State's outcomes for transition age youth, including:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including during times of crisis;
- Reduction in incarceration in jails and juvenile halls; and

- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements

Delegates also embraced three additional outcomes for transition age youth:

- Maintaining or improving physical health, as it relates to the achievement of the other outcomes;
- Reduction in early pregnancy; and
- Completion of high school diploma or a GED.

A note about age appropriateness and transition age youth:

Delegates fully appreciate the unique developmental challenges faced by this group of young people, above and beyond whatever mental health challenges they face. Our use of different phrases throughout this report, youth, young people, young adults, is intended to suggest some of these age-related developmental challenges.

All of the recommendations in this report, both within Full Service Partnerships and system development investments, presume a commitment to ultimately helping transition age youth who are receiving services to achieve the highest level of self-sufficiency possible. What this means in practice will vary depending on many factors including age, culture, and ethnicity. For many youth 16-18 or even older, helping them establish or re-establish appropriate relationships with family members or other adult caregiver is crucial to helping them progress toward self-sufficiency. Many young people, however, even some in younger ages, have already begun to transition to independence, and establishing relationships with family members or other adults must reflect this reality. The complexity of these dynamics reflects the essential requirement to tailor services and supports to the particular needs of the individual.

We understand that, as a general rule, all of the recommendations made here reflect a commitment to providing services to young people that support the maximum level of self-sufficiency possible regarding their relationships with their families and communities. We also understand that these services should be delivered wherever and whenever appropriate and possible.

3. Recommendations for Full Service Partnership Programs for TAY

Delegates embraced the definition of Full Service Partnerships for transition age youth as outlined above.

In addition, delegates agreed that one of the most essential elements for success of Full Service Partnerships is a strong commitment to meet the housing needs of enrolled youth and young adults. Delegates believe that such a commitment is crucial for

ensuring that youth and young adults enrolled in Full Service Partnerships have a stable environment in which to work toward recovery and wellness.

Included within the initial cost estimates for Full Service Partnerships for transition age youth are the cost estimates for a range of housing options to be made available to youth and young adults enrolled in these programs including:

- Hotel vouchers for emergency housing;
- Rental subsidies and vouchers;
- Access to housing, and housing with supportive services, specifically designated and designed for transition age youth with SED or SMI; and
- Other appropriate housing assistance.

ADULTS 26-59

1. Recommended Target Populations for Full Service Partnerships for Adults

The State Department of Mental Health August 1 guidelines recommended several groups of adults with serious mental illness as potential focal populations, including adults with a co-occurring substance abuse disorder and/or health condition who are either not currently served and meet one or more of the following criteria:

- Homeless;
- At risk of homelessness, such as youth aging out of foster care or persons coming out of jail;
- Involved in the criminal justice system, including adults with child protection issues; or
- Frequent users of hospital and emergency room services;

Or who are so underserved that they are at risk of:

- Homelessness, such as persons living in institutions or nursing homes;
- Criminal justice involvement;
- Institutionalization; or
- Transition age older adults (often between the ages of 55 and 59) who are aging out of the adult mental health system and at risk of any of the above conditions or situational characteristics are also included.

The delegates embraced the State's recommended focal populations, and further refined them as follows. We will focus our initial CSS Full Service Partnerships for adults on those people with serious mental illness, including people who have co-occurring disorders and/or have suffered severe trauma, who are so unserved or underserved as to be:

- Homeless;
- In jail;
- Frequent users of hospitals or emergency rooms;

- In other institutional settings (including State Hospitals, IMDs, Urgent Care Centers, various residential treatment and other facilities); or
- With family members or in other settings and, because of their mental illness, are at imminent risk of homelessness, jail, and/or institutionalization.

2. Recommended Outcomes

Delegates have embraced the outcomes for adults as specified by the State, including:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness
- A network of supportive relationships
- Timely access to needed help, including times of crisis
- Reduction in incarceration in jails and juvenile halls
- Reduction in involuntary services
- Reduction institutionalization
- Reduction in out-of-home placements

Delegates also embraced the additional outcome of maintaining or improving physical health as it relates to the achievement of the other outcomes for adults.

OLDER ADULTS 60+

2. Recommended Target Populations for Full Service Partnerships for Older Adults

The August 1, 2005 guidelines issued by the State Department of Mental Health recommended several groups of Older Adults 60 and older as candidates for target populations. These groups include older adults 60 years and older with serious mental illness, including older adults with co-occurring substance abuse disorders and/or other health conditions, who are not currently being served and:

- Have a reduction in personal or community functioning;
- Are homeless;
- At risk of homelessness, institutionalization, nursing home care, hospitalization and emergency room services; or
- Older adults who are so underserved that they are at risk of any of the above

Transition age older adults may be included under the older adult population when appropriate.

The delegates embraced the State's recommended focal populations, and further refined them as follows. We will focus our initial CSS Full Service Partnerships for older adults 60 years and older with serious mental illness, including:

- Individuals with co-occurring disorders that include substance abuse disorders, developmental disorders, medical disorders and cognitive disorders with a primary diagnosis of mental illness;
- Those at imminent risk for placement in Skilled Nursing Facility (SNF) or released from SNF, possibly conserved;
- Adult Protective Service-referred clients with a history of self-neglect or abuse and who are typically isolated;
- Clients at high risk of going to jail or released from jails;
- Intensive service recipients (clients with 6 or more hospitalizations in the past 12 months);
- Clients currently in the system who are aging up in the system, e.g., consumers who have suffered from severe mental disorders in earlier years who are now becoming senior citizens, perhaps currently in adult "ACT-like programs;" and
- Clients at high risk for suicide

3. Recommended Outcomes

Delegates have embraced the outcomes for older adults as specified by the State, including:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including times of crisis;
- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

Delegates modified the language of these outcomes to more appropriately apply to older adults to include:

- An affordable, safe and nurturing environment that is, as least restrictive as possible, supporting optimal functioning in a safe living arrangement;
- A meaningful way to use one's time, including a sense of community connectedness, and feelings of value and esteem within the community;
- Meaningful and supportive relationships with others ;
- A full array of culturally sensitive, age appropriate mental health and supportive services, available in all geographic areas;
- Maintaining optimal functional ability and physical, cognitive and mental health; and
- Ability to exercise self-determination.

3) Describe any housing or employment services to be provided through the Full

Service Partnerships for all age groups/

We anticipate providing housing and employment services through Full Service Partnerships for all age groups under the "whatever it takes" commitment that defines these services.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

To answer this question will require some explanation.

Conservative estimates calculate the unmet need in Los Angeles County for mental health services for those suffering from severe mental health issues at over 112,000 people (See pp.. 42-55 of the Los Angeles County Community Services and Supports Plan for an analysis of the data that produced this estimate.) When fully staffed and operational, the Full Service Partnerships will support 4,333 people and their families. The relative impact these initial Full Service Partnerships will have, therefore, is small. Our intention, however, is to use these investments to help us learn how to more effectively and efficiently create the broad range of supports that individuals need to accelerate their recovery. Moreover, we are committed to use these new funds to learn how to set and meet targets for different populations so that we can pursue a more ambitious agenda of addressing disparities in access to services in coming years.

We have begun to act on this commitment as follows. We first identified several criteria to help us set preliminary targets for Full Service Partnerships to different ethnic groups by age and by service planning area. These criteria included: poverty by age by ethnicity by service area; the number of uninsured by age by ethnicity by service area; and number of households where English is not the primary language by age by ethnicity by service area.

We quickly discovered that reliable data by age by ethnicity by service planning area only exists for the poverty criterion; the other two criteria can only be analyzed Countywide or by service planning area, but not by age by ethnicity by service area.

The delegates decided to start with the poverty data and do a first calculation of countywide slots by ethnicity. We will then analyze the demographic data for the various focal populations by service area and begin to develop coherent designs for Full Service Partnerships that will stay within the recommended allocations. We will then monitor these targets on a quarterly basis, reporting back to the delegates our progress and identifying where we may need to strengthen our outreach and engagement efforts. Additionally, we will create some specialized slots for dispersed ethnic and special populations—e.g., American Indians—to insure we are creating services for those populations and learning how to improve the larger service system's efforts on their behalf.

One last calculation we have done relative to the allocation of Full Service Partnerships is to set targets for the uninsured in Los Angeles County. We have set ambitious targets for reaching the uninsured in each age group in order to insure that these funds provide support and hope for the most vulnerable citizens with mental health needs in our community. Specifically, these targets are: 10% for children, 35% for transition age youth, 35% for adults, and 20% for older adults. That is, the expectation is that we will serve at least this percentage of people who will not have access to other payer sources for a year or longer. These targets do not reflect any diminishment of the system's commitment to aggressively pursue and establish benefits for all who are eligible; instead the targets are intended to reflect the intention to reach the most unserved and difficult to serve among the various age groups.

Note that these targets are for actual people served, not for MHSA dollars allocated. This distinction has important implications for the calculations in the next section about numbers to be served. To estimate the total number of people to be served through Full Service Partnerships, we have to distinguish between 3 groups of people:

- Those who have benefits—e.g,. Medi-Cal—on the day they enroll in a Full Service Partnership (Insured);
- Those who do not have benefits on the day they enroll but who will have benefits established at some time during the year (Will be Insured); and
- Those who will not be able to have benefits established for them at any point in the program (Uninsured).

The targets we have set for the uninsured relate to this last group—those who will not be able to have benefits established for them at any point in the program (uninsured). For example, we expect more than 35% of adults who enroll in Full Service Partnerships to begin these programs without any alternative payer source. We project, however, that after our best efforts to establish benefits for all of these adults that at least 35% of them will still be uninsured. Again, the importance of this commitment is to insure that we are designing our outreach and engagement efforts to reach the most vulnerable citizens with mental health needs in our community.

To meet these targets, however, requires that we estimate the amount of funds to be leveraged with MHSA dollars, and to insure that we have sufficient *unencumbered MHSA funds* (funds not used to match alternative payer sources) to be able to provide services to the numbers of people we want to serve who do not have benefits. These funds fall into two categories:

- Funds to provide all services to the *Uninsured*; and
- Funds to provide all services to the *Will be Insured* for the period of time they do not have benefits.

A third category of funds also has to be set aside: funds for those services that will not be reimbursed regardless of who receives them. Full Service Partnerships embody a "whatever it takes" commitment, meaning that every effort is made to provide whatever

services a person needs in order to make significant progress toward recovery and wellness. Many of these services, however, will not be reimbursable under Medi-Cal or other benefits programs—e.g., outreach and engagement services, housing services, or employment services. So-called "flexible funds" have to be set aside and not used to leverage other funds in order to insure that sufficient resources are available to pay for these non-reimbursable but essential services.

Calculating the precise amount of funds that have to be withheld from any leveraging projections, and the precise average cost of the non-reimbursable services to be provided, is more art than science at this stage in our development. While we have substantial experience administering AB 2034 programs for adults and Wraparound programs for children, we have very little experience developing and implementing Full Service Partnership programs for the older adult and transition age youth focal populations. Moreover, even within our adult and children focal populations, estimating the amount of dollars required for outreach and engagement efforts, a crucial component of flex funds, and the precise amounts of additional funds that may be required for housing, employment services, and other more expanded non-traditional mental health services that will be essential for achieving the expected outcomes for the most severely and persistently mentally ill people who are the target of Full Service Partnerships in this first plan.

We have attempted to reflect these various uncertainties for now by showing ranges of numbers to be served, and ranges for the estimated average costs per client. Note that for the projected budgets required by the State, we have used the *lower* estimates of numbers to be served for every age group *except* for Older Adults, where we used the higher estimate. We will continue to refine our estimates of these numbers over the next month as we finalize the design criteria for Full Service Partnerships targeting each focal population.

1. Children 0-15
   a. Total children to be served through Full Service Partnerships
      (1) FY 2005-06: 384-409
      (2) FY 2006-07: 1534-1638
      (3) FY 2007-08: 1534-1638
   b. Estimated average cost per client: $16,500-$17,615
   c. Estimated percentage of children receiving services who will be eligible for alternative payers sources at some time during a full year of service: 90%
   d. Estimated annual amount to be leveraged through Early Periodic Screening, Diagnosis, and Testing (EPSDT) funds when fully operational: $21,607,465

2. Transition Age Youth 16-24
   a. Total TAY to be served through Full Service Partnerships
      (1) FY 2005-06: 207-234
      (2) FY 2006-07: 828-938
      (3) FY 2007-08: 828-938
   b. Estimated average cost per client: $15,520-$17,580

c. Estimated percentage of children receiving services who will be eligible for alternative payers sources at some time during a full year of service: 65%
d. Estimated annual amount to be leveraged through Early Periodic Screening, Diagnosis, and Testing (EPSDT) funds, Medi-Cal funds, and Healthy Families when fully operational: $7,839,128

3. Adults 25-59
   a. Total to be served
      (1) FY 2005-06: 441-664
      (2) FY 2006-07: 1766-2657
      (3) FY 2007-08: 1766-2657
   b. Estimated average cost per client: $15,000-$22,567
   c. Estimated percentage of adults receiving services who will be eligible for alternative payers sources at some time during a full year of service: 65%
   d. Estimated annual amount to be leveraged through Medi-Cal when fully operational: $8,911,440

4. Older Adults 60 +
   a. Total to be served
      (1) FY 2005-06: 31-41
      (2) FY 2006-07: 158-205
      (3) FY 2007-08: 158-205
   b. Estimated average cost per client: $15,000-$19,447
   c. Estimated percentage of older adults receiving services who will be eligible for alternative payers sources at some time during a full year of service: 80%
   d. Estimated annual amount to be leveraged through Medi-Cal when fully operational: $973,844

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Full Service Partnerships are by design grounded in a commitment to recovery. Full Service Partnerships are voluntary, and begin with a plan that is co-created with the person who is receiving services and his or her family where appropriate. Training in the principles of recovery, wellness, and resiliency will be regularly provided to providers of Full Service Partnerships and related community-based organizations.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Not applicable

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

We expect people who receive services and family members to be part of staffs of organizations who deliver Full Service Partnerships.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

We expect providers of Full Service Partnerships to develop effective collaborations with myriad community-based organizations who serve the various focal populations for Full Service Partnerships. This will be one of several essential criteria in assessing the strength of a potential provider's application to deliver Full Service Partnership services.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

We expect providers of Full Service Partnerships to demonstrate a history of delivering culturally appropriate and culturally competent services, including having staff that speak the language(s) of the focal populations and other measures of cultural competence. This will be one of several essential criteria in assessing the strength of a potential provider's application to deliver Full Service Partnership services.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

We expect providers of Full Service Partnerships to demonstrate a history of delivering services that are sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls. This will be one of several essential criteria in assessing the strength of a potential provider's application to deliver Full Service Partnership services.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Not applicable

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
September	Develop consensus among delegates on initial provider selection and program design criteria for Full Service Partnerships
October	Work with County Counsel, CAO, and others to develop streamlined RFI process
November–December	Execute RFI process; Identify initial providers
December	Initiate Provider Selection Process

2006	
January	Develop Board letter for first round of contracts
February	Select Providers
March	Negotiate Contracts
	Develop Policies and Procedures
April	Submit CDAD Service Request
	Submit Budget Transfer Request
May-June	Program Fully Operational
Ongoing	Continue interdisciplinary team meetings
	Continue collaboration with primary care
	Continue enrollment of clients

2007	
June	Evaluate effectiveness of field sites
July	Conduct evaluation of enrollment/disenrollment procedures and modify as needed

2008	
January – December	Expand enrollment of clients
March	Evaluate effectiveness of field sits
April	Evaluate need for additional providers
May	Initiate provider selection process as needed
July	Select provider as needed
	Prepare Board Letter Draft
August	Prepare Budget Documents (as needed)
	Submit CDAD Service Request (as needed)
	Submit Budget Transfer Request (as needed)
	Submit PFAR (as needed)
October	Begin site Medi-Cal certification procedure
	Secure Medi-Cal Certification

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Budget worksheets have been completed on each of the four Full Service Partnerships and are included in Exhibit 5.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

SYSTEMS DEVELOPMENT INVESTMENTS FOR CHILDREN

C-02: Family Support Services

1) Complete Exhibit 4 (as required under Section IV response)

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Family Support Services program is designed to provide parents/caregivers of a child with SED access to mental health services for themselves. The program is based on the belief that providing treatment to parents and/or caregivers with mental health needs is critical to the successful achievement of outcomes for children.

In many instances, parents/caregivers have mental health needs that do not rise to the level of the adult system. However, their symptoms often interfere with their ability to care for their SED child. The Family Support Services program will offer individual therapy, couples therapy, parenting education, peer support groups, substance abuse and domestic violence counseling. The program targets those without other funding sources, those who are not covered under the adult system of care and those for whom collateral services are insufficient.

MHSA funds are being requested to provide treatment to parents/caregivers in order to address their mental health needs. Treatment will be strength-based and solution-focused. Interventions will focus on symptom reduction and improving coping strategies to deal with internal and external stressors.

MHSA funds are the only funding source for this program because it is intended for parents/caregivers who do not have access to other funding sources.

The Family Support Services program advances the goals of MHSA in several areas. Services to parents/caregivers will be culturally competent including providing treatment in the primary language of the family. Cultural strengths of the family will also be utilized in the service delivery.

The treatment will be client-driven. As with the adult system, parents/caregivers will identify their needs and preferences, which will lead to the services and supports that will be most effective for them. Services will also be integrated. Parent/caregiver treatment will be integrated with the treatment of their child and family. Joint planning will be utilized to address the needs of the family as well as the individuals being

served. Treatment will also incorporate services for substance abuse and domestic violence.

3) Describe any housing or employment services to be provided.

N/A

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The Family Support Services program will have a wellness focus. Parent/caregiver treatment will focus on symptom reduction or the elimination of symptoms. The goal is to empower parents/caregivers to live, work, learn and participate fully in their families and communities.

Treatment will also incorporate the concepts of resilience. Strength-based approaches will be utilized and will focus on enhancing problem-solving skills. Developing and/or improving close relationships within the family and connecting to community supports will also be a focus of treatment.

The values of recovery and resiliency will be promoted and reinforced in several ways. Initially, it will be necessary to provide training to clinical and administrative staff about the recovery model. Training can include workshops as well as on-the-job mentoring. Tracking outcomes within a resilience and recovery framework will also be important to promote and reinforce these principles. Examples of outcomes would be symptom reduction and improvement in self-efficacy.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

The Family Support Services program is a new program.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

The Family Support Services program will have a peer support component. The purpose of peer support is to enhance the socialization skills, parenting skills, and

communication skills of the parents/caregivers. This is accomplished through the development of parent self-esteem, the development of community networking skills and respect for cultural heritage and identity.

The peer support component will allow parents/caregivers to share experiences, coping mechanisms and discuss problems with people who share similar experiences. The goal of the peer support component is to reduce isolation and develop community supports. Parents will be participating in the peer support component as part of the service program.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The Family Support Services program will collaborate with other stakeholders to ensure that parents and their families are receiving comprehensive care. This will include outreach to community partners such as faith-based organizations, cultural organizations including tribal governments, churches, employment services, housing organizations, domestic violence agencies, food banks, and other supportive services.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The Family Support Services program will be culturally competent by utilizing culturally and linguistically sensitive approaches that are strength-based and family-focused. Workforce development is also an important component of being culturally competent. Mental health providers will be encouraged to hire qualified bilingual/bicultural professionals, paraprofessionals and consumers who live in and/or reflect the demographics of individual communities.

The Los Angeles County Department of Mental Health will assist with the identification of the unserved, underserved and inappropriately served ethnic populations by service area. This will ensure that local communities are able to identify the language, cultural needs and demographics of their area.

Once needs are identified by service area, efforts will be made within the Family Support Services program to engage parents, families, and community members in culturally effective ways at all levels, including developing treatment options, planning, advocacy, accountability, employment and education.

Community outreach and engagement is another way to address the ethnic disparities identified in the plan. Qualified bilingual/bicultural professionals, paraprofessionals,

advocates, consumers and family members who live in and/or reflect the demographics of individual communities will participate in outreach and engagement. These individual will help to link the underrepresented ethnic populations to mental health services.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

In order to ensure that services are provided in a manner that is sensitive to sexual orientation and reflects differing gender psychologies, it will be important to provide training for clinical and administrative staff in clinical approaches that are sensitive to sexual orientation issues. On-going case consultation and clinical supervision will also be necessary to ensure that these issues are consistently being considered and addressed.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Los Angeles County continues to work with the California Institute of Mental Health (CIMH) and the Zellerbach Foundation to conduct a study of how to improve access to mental health services between counties throughout the State. Upon completion of the study, recommendations will be submitted to the California Mental Health Director's Association (CMHDA) for consideration of implementation.

Although not specifically referenced in the Children's Work Group report and recommendations for MHSA, access to mental health services for children and families residing outside of Los Angeles is a critical component. Specialist Service Area Navigators with training, knowledge and experience in inter-county relations will provide the valuable linkage to services outside of Los Angeles, contingent upon the other 57 counties having similar components in place to accommodate the needs of this population.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
November	Design Program, including staffing Develop Criteria for Provider Selection
December	Initiate Provider Selection Process

2006	
February	Select Providers
	Prepare Board Letter Draft
March	Negotiate Contracts
	Develop Policies and Procedures
April	Submit CDAD Service Request
	Submit Budget Transfer Request
	Develop Training Plan
May-June	Program Fully Operational
Ongoing	Continue interdisciplinary team meetings
	Continue enrollment of clients

2007	
June	Evaluate effectiveness of field sites
July	Evaluate enrollment/disenrollment procedures, modifying as needed

2008	
Jan-Dec	Expand enrollment of clients
March	Evaluate effectiveness of field sites
April	Evaluate need for additional providers
May	Initiate Provider Selection Process (as needed)
July	Select Provider (as needed)
July	Prepare Board Letter Draft
August	Prepare Budget Documents (as needed)
	Submit CDAD Service Request (as needed)
	Submit Budget Transfer Request as needed
	Submit PFAR as needed
October	Begin Medi-Cal Site Certification Procedure
October	Secure Medi-Cal Certification

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

C-03: INTEGRATED MENTAL HEALTH/CO-OCCURRING DISORDERS SERVICES

1) Complete Exhibit 4 (as required under Section IV response)

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Children & Youth Co-Occurring Disorders Program proposes to develop and implement a developmentally appropriate coordinated/integrated approach to service delivery for children and adolescents with co-occurring disorders (COD) that will offer a full continuum of services to meet treatment needs and establish other service linkages to help maintain and sustain the child's/youth's recovery.

The priority sub-populations to be served in the first three years of the Community Services and Supports (CSS Plan) are (in order of priority): (1) youth with COD in the foster care and juvenile justice systems, homeless youth, trauma survivors and victims, and indigent youth who experience frequent or long-term health crises; (2) children and adolescents with serious emotional disturbance and a substance abuse disorder, and pregnant women and parents with COD; (3) underserved ethnic minority populations (emphasis should be placed on providing culturally and linguistically appropriate outreach and services to address their needs).

For each of the following strategies, the target age group will be children and youth:

Strategy 1: *Identification, replication, and expansion of existing effective, coordinated and integrated COD prevention and treatment program models.*

Strategy 2: *Intensive training for mental health and substance abuse treatment personnel on best practices in preventing and treating persons with COD using coordinated/integrated program models (includes practicum experiences and supervision by expert consultants).*

Strategy 3: *Incorporating Alcohol and Other Drug (AOD) assessment and referral staff that are well trained in COD in selected facilities, including Urgent Care Centers (UCCs).*

Strategy 4: *Capacity expansion for placement of UCC/Psychiatric Emergency Services (PES) COD referrals in existing, as well as expanded, community-based programs which meet the criteria for implementation of best practice COD service models*.

The Children & Youth Co-Occurring Disorders Program is strategically essential to support the effective implementation of Full Service Partnerships (FSP) and includes

developing fully-integrated COD models and modules that address both children and caregivers with COD's, as well as children without COD's that have a caregiver with a COD. Also, when appropriate and necessary, this program will allow the treatment of children with COD's using treatment goals that do not tie directly to their mental health diagnosis. Furthermore, it will allow for the hiring of COD/substance abuse specialists and managers.

The Children & Youth Co-Occurring Disorders Program will advance the goals of the MHSA, since it addresses the following proposed outcomes of the MHSA. The program will enable the child/youth to:

- Engage in meaningful use of time and capabilities, such as education, social and community activities;
- Enjoy a safe living environment with family and a reduction in homelessness through the expansion of residential treatment programs (including residential detoxification);
- Enjoy a network of supportive relationships through the expansion of prevention services targeting risk and resiliency factors for COD, as well as through the co-location of mental health and substance abuse services in the same facility with a multidisciplinary team approach, community involvement, and self-help groups;
- Experience timely access to needed help, including times of crisis, through the expansion of psychiatric emergency services that address the needs of children and youth with COD;
- Experience a reduction in incarceration in jails and juvenile halls though the proposed prevention and early intervention services specifically targeting risk and resiliency factors for COD;
- Experience a reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements by providing a coordinated/integrated comprehensive continuum of care and services for children and youth with COD, including prevention, early intervention, treatment, and aftercare.

3) Describe any housing or employment services to be provided.

N/A

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The components of the Children & Youth Co-Occurring Disorders Program will advance the goals of resiliency for children and youth in that it will provide for a coordinated/integrated comprehensive continuum of care and services at a consistently high quality level for all services for children and youth with COD. Comprehensiveness is a system of care principle that calls for addressing all of the important life domains of developing children and youth: their physical, emotional, social and educational needs. Furthermore, it will be holistic, individualized, community-based, and culturally competent; will include early intervention and full family participation; will involve integrated service coordination, interagency coordination, and support for transitions, all of which are principles of recovery and resiliency.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Presently, the mental health and AOD systems of care have limited effectiveness in preventing and treating COD among children and adolescents in Los Angeles County. The two systems generally operate independently of one another. The current program will change under this proposal by becoming a coordinated/integrated approach, which the research literature demonstrates would greatly strengthen services for this focal population (children and youth with COD). Furthermore, the following services are currently inadequate or very limited, and will be expanded:

- Family-focused treatment services for youth with COD.
- Treatment services for youth with COD that do not meet diagnostic criteria to qualify for DMH services, yet which may impair functioning if left untreated.
- Residential treatment services (including residential detoxification).
- Psychiatric emergency services that address the needs of persons with COD in crisis.
- Prevention services specifically targeting risk and resiliency factors for COD.

Other changes that will take place under this proposal are the following:

- Ongoing/enhanced training for clinical supervisors and psychiatrists (including incentives for them to treat CODs), as well as appropriate executives/managers from selected programs.
- Cross hiring: mental health agencies will hire substance abuse counselors and substance abuse programs will hire mental health professionals, with equal authority and appropriate compensation.
- Locating mental health and substance abuse services in the same facility with a multidisciplinary team approach, community involvement, and self-help groups.
- Utilizing university-based research groups to conduct thorough analyses of mental health and substance abuse service capacity across multiple systems, particularly unmet gender-specific needs among transition-age and high-risk youth, (e.g., GLBT high school students, homeless and runaway youth).
- Offering a full continuum of services at a consistently high quality level for all services.

- Codifying workforce qualifications and standards as well as program standards.
- Programs and providers will incorporate “best practices” that have emerged from the youth development literature.
- Effective interventions targeting youth will address the growth-related tasks that young people must complete.
- Providers will demonstrate knowledge and skill competencies in adolescent-specific care, and will demonstrate relationships with other agencies and institutions in the community to ensure that children and youth with COD have access to comprehensive services that address their unique needs.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

The Children & Youth COD Program plans to increase the use of consumers (clients and/or families) as staff members in service delivery. They will provide and also benefit from the following services and supports that will be offered to children and youth with COD:

- Develop a coordinated/integrated comprehensive continuum of care and services for persons with COD (research findings and a consensus of practitioners emphasize the use of integrated mental health and substance abuse treatment services as the only effective clinical practice for successfully assisting persons with COD), including prevention, early intervention, treatment and aftercare. This continuum would involve both County-operated and community-based programs (including DMH, DHS-ADPA, DCFS, Probation, schools) as integral service delivery components.
- Build the capacity of community-based providers under the mental health and substance abuse systems to serve the needs of persons with COD at multiple points of entry.
- Interpret the definitions of substance abuse and mental disorders as broadly as possible to include all uninsured persons who may be classified among the identified focal populations with the highest illness burden; the system should address both mental health and substance abuse disorders as primary diagnoses.
- Provide outreach and, where appropriate, early identification and screening through a variety of systems (mental health, schools, health care settings, juvenile justice, community-based agencies, faith-based organizations).
- Use programs and services that describe a developmental trajectory for children and adolescents; prevention of COD in youth will be one of the major components.
- Identify system, program and workforce competencies, qualifications, development and training needs
- Identify current legal, regulatory, and financial barriers to coordinated/integrated services and approaches to overcome them (include a multi-year time frame).

Children and youth with COD, and their family members, will be a part of the planning process that will implement each of the aforementioned services and supports for children and youth with COD.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The COD Committee was 1 of 45 committees established by DMH to obtain recommendations from stakeholders on how Los Angeles County should implement programs and services funded by the Mental Health Services Act/Proposition 63 (MHSA) that was approved by California voters in November 2004. Conveners of the committee were Dr. Roderick Shaner, DMH Medical Director; Dr. Vivian Brown, Chief Executive Officer for Prototypes; Patrick Ogawa, Director of the Alcohol and Drug Program Administration, Department of Health Services (ADPA); and Fernando Escarcega, DMH District Chief. COD Committee members consisted of representatives from various DMH programs, members of the Mental Health Commission and the Narcotics and Dangerous Drugs Commission, consumers of DMH and ADPA programs, representatives of the Department of Health Services, and other interested persons from community-based programs, including persons from programs serving consumers from various ethnic groups (such as Latino, African-American, Native American, and Asian-American groups).

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The AOD system of services features population-specific programs and services for all major cultural and non-English speaking groups. It also features training and technical assistance for service providers addressing population-specific programs and services for all major cultural groups. Training is a critically needed component for building a culturally and linguistically competent coordinated/integrated system of services as a priority outcome. Furthermore, expanding and enhancing PES and existing treatment services increases access for children and youth with COD to culturally and linguistically appropriate services.

The Children & Youth Co-Occurring Disorders Program will work closely with the Los Angeles County Planning Division to gather information from population data for LA County and any available estimates of underserved and unserved ethnic minority populations. Furthermore, a countywide needs assessment will be conducted in LA County that will target various ethnic minority populations such as Native American, Asian-American, Latino, African-American, and other ethnic groups, to assess the needs of children and youth with COD from those ethnic groups. Once the needs of the

various ethnic groups are identified, leaders from each of these communities will be identified (by each of these communities themselves) and will be approached to assist in the planning and implementation of culturally-specific, culturally relevant, and culturally proficient services for children and youth with COD within these various communities of underserved and unserved ethnic minority groups.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The AOD system of services features gender-specific and other population-specific programs (women, gay/lesbian/transgender/transsexual persons). The AOD system of services features training and technical assistance resources on gender-specific competency. Training is an essential program component for building a gender competent coordinated/integrated system of services as a priority outcome. Expanding and enhancing PES and existing treatment services increases access for children and youth with COD to gender-appropriate services.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

N/A

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
November	Design Program, including staffing
	Develop Criteria for Provider/Consultant Selection
December	Initiate Provider/Consultant Selection Process

2006	
February	Select Providers/Consultants
	Prepare Board Letter Draft
March	Negotiate Contracts
	Develop Policies and Procedures
April	Submit CDAD Service Request
	Submit Budget Transfer Request
	Develop Training Plan

April - ongoing	Staff Training
May-June	Program Fully Operational
Ongoing	Continue interdisciplinary team meetings
	Continue enrollment of clients

2007

June 2007	Evaluate effectiveness of field sites
July 2007	Evaluate enrollment/disenrollment procedures modifying as needed

2008

January - December	Expand enrollment of clients
March	Evaluate effectiveness of field sites
April	Evaluate need for additional providers
May	Initiate Provider/Consultant Selection Process as needed
July	Select Providers/Consultants as needed
	Prepare Board Letter Draft
August	Prepare Budget Documents as needed
	Submit CDAD Service Request as needed
	Submit Budget Transfer Request as needed
	Submit PFAR as needed
October	Begin Medi-Cal Site Certification Procedure
	Secure Medi-Cal Certification

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

C-04: FAMILY CRISIS SERVICES: RESPITE CARE

1) Complete Exhibit 4 (as required under Section IV response)

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Respite Care is a support service for families providing constant care for a person with a disability or serious illness. Respite care programs are designed to help relieve families from the stress and family strain that results from caring for a disabled child or adult. Available as a service to families in the developmental disabilities system for over 20 years, respite care has proven itself to be the most cost-effective family support system. Families in the same circumstances in the mental health system have done without, suffering in silence. Countless tragedies, where families with a seriously mentally ill family member have been torn apart due to the immense stress of caregiving, could have been prevented had respite care been available.

In the year 2000, the California State Legislature included language in the State Budget to establish Mental Health Respite Care Pilot Project to be administered by county mental health departments. Chapter 93, Part 3.5 language stated that "*respite care provided to families caring for a seriously emotionally disturbed child or seriously mentally ill adult is critical to assist them in keeping their family member in the home and maintaining the stability of the family.*"

Currently available only to families in the developmental disabilities system, it is important to make respite care available to family members of children and youth, ages 0-15, who meet the eligibility criteria of Full Service Partnerships.

Eligibility will be based on the former language in the State Welfare and Institutions Code Section 5833:

> *"Parents and other family who provide care in their home for a serious emotionally disturbed child… shall be eligible for respite care … when … both the following conditions are met: (1) the caregiver is under significant stress as a result of the responsibility of providing care; and (2) continued care taking without respite care may result in out-of-home placement or a breakdown in the family stability."*

Respite care will be made available to families enrolled in Full Service Partnerships that are providing in-home care for their mentally ill child when both of the above conditions are met. Each family will then be responsible for identifying a respite care worker to care for their mentally ill relative. Families can receive up to 16 hours of respite care per month, with additional hours (that must be pre-authorized) provided under exceptional circumstances. Respite care workers will be paid $10 per hour and will bill the agencies directly.

The respite care program converges with all children's programs and services through supporting caregivers and advances the MHSA goal of reducing institutionalization and out-of-home placement. Further, the respite care program under the developmental disabilities system has proven to be the most cost-effective family support service. It enables families to care for their disabled family member at home, preserving the family unit and avoiding the cost of expensive out-of-home care. The Mental Health Respite Care Pilot Project found that the 83 families participating in the 6-month pilot had zero out-of-home placements, which illustrated a potential cost-savings of $361,800 for every month no children required placement (see Pacific Clinics' "News Flash," May 2001). Families reported outcomes that resulted in safer living environments for the mentally ill relative as well as an increase in supportive relationships. *"Families reported that they were in a better mental state and more able to patiently meet the needs of their ill relative." "The mentally ill individual's behavior often improved as result of the caregiver's more relaxed state." "Family members were able to attend church and other social engagements."*

3) Describe any housing or employment services to be provided.

N/A

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The respite care program will advance the goals of resilience in children and youth. The respite care program facilitates caregivers' ability to maintain close relationships with the mentally ill family member due to the stress relief and improved mood of the caregiver. The program also enables the caregiver to build social support systems and extend the family network. Each of these characteristics are identified as components of resilience as described by Luthar, Cicchetti, & Becker (2000). Finally, toward the goal of recovery, the Mental Health Respite Care Pilot Project found that the mentally ill individual's behavior often improved as a result of respite care. Improved behavior would facilitate the mentally ill family member's ability to live, learn, work, and participate in the community.
The values of resilience and recovery will be continually reinforced in that eligible families will be able use the service continually, as needed, for up to 16 hours per month.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

There is no existing Respite Care Program for the mentally ill.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Families will be partners in that they themselves will select their respite care worker. In addition, families often elect to use a family member as their respite care worker, thus building on their family support system.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

N/A

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Families will elect their own respite care worker to ensure that the services provided are consistent with the culture and language of their family.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Families will elect their own respite care worker to ensure that the services provided are sensitive to sexual orientation, are gender-sensitive, and reflect the psychologies of men, women, boys and girls.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county. N/A

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA. N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
November	Design Program
	Develop Eligibility Criteria for Respite Care Services
December 2005	FSP Provider Selection Process

2006	
February	Select FSP Providers
	Prepare Board Letter Draft for FSP
March	Negotiate FSP Contracts
	Develop Respite Care Policies and Procedures
April	Submit CDAD Service Request for FSP
	Submit Budget Transfer Request for FSP
May-June	FSP Program Fully Operational/Respite Care Available
Ongoing	Continue enrollment of clients and families in FSP

2007	
June	Evaluate effectiveness of FSP field sites and Respite Care Services
July	Evaluate enrollment/disenrollment procedures modifying as needed

2008	
January - December	Expand enrollment of clients and families
March	Evaluate effectiveness of field sites
April	Evaluate need for additional FSP providers
May	Initiate FSP Provider Selection Process (as needed)
July	Select FSP Provider (as needed)
	Prepare Board Letter Draft for FSP Provider
August	Prepare Budget Documents (as needed)
	Submit CDAD Service Request (as needed)
	Submit Budget Transfer Request (as needed)
	Submit PFAR (as needed)
October	Begin Medi-Cal Site Certification Procedure
October	Secure Medi-Cal Certification

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

TRANSITION AGE YOUTH SYSTEMS DEVELOPMENT INVESTMENTS

T-02: DROP-IN CENTERS

1) Complete Exhibit 4 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Transition Age Youth who are SED or SMI have challenges that are unique and separate from the challenges faced in the general children and adult populations. These challenges often interfere with their ability and willingness to connect with the therapeutic and transitional living assistance that they need to avoid homelessness or lifelong institutionalization in correctional facilities and other involuntary settings. The vast majority of these youth are either former foster youth or youth emancipating from the probation system. In both cases they are usually disconnected from their families.

Drop-in centers are intended as entry points to the mental health system for youth who are living on the street or in unstable living situations. The target sub-population for drop-in centers is often “service-resistant.” Most of these youth suffer attachment disorders, and have been betrayed by most of the adults in their lives - significantly complicating efforts to connect them with services. Drop-in centers provide “low demand, high tolerance” environments in which youth can find temporary safety and begin to build trusting relationships with staff people who can, as the youth is ready and willing, connect them to the services and supports they need.

Drop-in centers are currently operated during normal business hours. An investment of MHSA dollars will allow for expanded hours of operation, during nights and weekends when access to such an environment is even more critical.

In some cases, drop-in centers will be co-located with Transitional Resource Centers (TRCs). TRCs are a joint effort of the Los Angeles County Departments of Children and Family Services and Probation in collaboration with multiple community agencies, to create one-stop centers where youth emancipating from Probation and DCFS can be provided with the support and linkages they need to establish themselves positively in the community.

Transitional Resource Centers currently exist in eight communities where there are disproportionately high numbers of youth at risk of homelessness. Independent Living Program (ILP) Coordinators from both Probation and DCFS currently staff these

centers. In addition, staff from non-profit and other government agencies bring added services to these sites. The Department of Public Social Services, for example, has agreed to place eligibility workers in the TRCs to assist youth with applications to GR, CalWorks and Food Stamps. All TRCs strive to offer a full continuum of activities that are of interest to youth and services that they need through in house programming and extensive partnerships with community stakeholders,

This continuum of services includes employment, educational and housing opportunities, youth activities and community events, as well as desperately needed health and human services, including substance abuse treatment. Mental health services are not currently available in the TRCs, nor are there clinical staff available to conduct appropriate mental health assessments.

On site assessment is a critical capacity to develop within the TRC structure. The target youth sub-population these centers are designed to serve need immediate connection to services when they are open to receiving them. They are often unable and/or unwilling to return on another day, or visit a secondary location for the assessment necessary to connect them with services.

MHSA funds will allow us to increase the assessment and linkage aspects of a traditional mental health services infrastructure for this high need population by placing "TAY Specialists" in a trusting, welcoming, youth-friendly environment where there are both activities and relationships that are attractive to young people. TAY specialists are mental health clinicians who serve as age-specific "systems navigators" who are capable of conducting in depth assessment as needed.

Additional "TAY Specialists" will be assigned to work collaboratively with staff in the probation camps and halls as well as in high end group home settings and other locations where high risk youth are found, to help youth connect with services and supports *before* they emancipate and/or transition back into the community.

TAY specialists are charged with assessing youth's needs, and connecting them with appropriate resources including Full Service Partnership Programs for those youth who are eligible. Additionally these TAY specialists will advocate for youth in connecting them to public benefits, and providing an additional point of "low demand re-entry" for youth who for one or another reason fall out of contact with their FSPPs or other services.

3) Describe any housing or employment services to be provided.

N/A

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The one-stop center approach described above will complement and facilitate therapeutic goals, recovery and a youth's achievement of her or his full potential as a vital member of the community, by connecting them with resources that not only address their needs, but also allow them to pursue their recreational, educational and career interests.

By understanding and tapping into the points of voluntary contact that these youth tend to seek, this approach maximizes the opportunities for meaningful engagement with them in ways most consistent with the goals of resiliency and recovery. Since the onset of profound mental illness is often experienced during the late teenage years, this investment becomes an invaluable opportunity to engage these at risk youth early and connect them to a full array of services, supports and opportunities that will greatly increase their resilience and likelihood of recovery.

If consistent with their goals for recovery, all efforts will be made to help reconnect youth with family and other supportive adults in their lives.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Investments will expand the operational hours at drop-in centers, including hours at the TRCs. Expansion of hours by approximately 32 hours per week in each of two locations during year one will allow for contact with 8 unduplicated youth per week over 52 weeks, or 416 youth per site, for a total of 1,248 youth/year and 3,744 youth over 3 years.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

As with all positions of outreach and engagement/case-management, people with relevant life experience have a unique ability to understand and connect with the experience of these high-risk youth. TRCs always strive to include youth counselors in their staffing patterns.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

This program plan has been developed through a collaborative effort with approximately 90 public and private partners that serve or have contact with TAY as well as parents, TAY consumer advocates and TAY consumers. The proposed expansion will broaden the collaboration between DMH, the County Departments of Children and Family Services and Probation, and multiple community agencies.

In some cases, drop-in centers will be co-located with Transitional Resource Centers (TRCs), a joint effort of the Los Angeles County Departments of Children and Family Services and Probation in collaboration with multiple community agencies, to create one-stop centers where youth emancipating from Probation and DCFS can be provided with the support and linkages they need to establish themselves positively in the community.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Drop-in Centers and TRC's are community based. They reflect the particular characteristics of the communities in which they are located. Staffing takes into account the need for language and cultural competency, and the collaboration of community agencies in these centers draws upon the strengths and resources already present in the community, many of which are grounded in local cultural contexts.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

All program and expenditure plans funded under the CSS plan will be sensitive to and address issues of sexual orientation and the differing psychologies of males and females. It will address issues related to gender and sexual orientation by relying on evidence-based assessment, intervention and support strategies. Some examples include:

- Development of referral sources for appropriate housing options that provide for the array of sexual orientations and preferences; and
- Service Area and System Navigators that have knowledge of and access to services that are sensitive to the needs of clients who are gay, lesbian, bi-sexual, transgender or questioning.

One such example is the TRC in South Central Los Angeles which hosts the "Girls Collaborative" whose primary goal is the recognition of the diverse needs of young women who have experienced sexual abuse, discrimination, or who have unmet mental health needs putting them at risk of homelessness or incarceration.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

No out of county services anticipated.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

The timeline for the Drop-in Centers /TRCs are based on a projected program implementation date of early 2006. This will be dependent on the funding allocation coming into the County during the month of January. This work plan calls for an October 2005 start date, for the action steps needed to implement the program in February. The tasks to be accomplished are as follows:

Drop-in Centers *(expansion of existing services by contract providers)*

2005	
October	Develop criteria for Provider Selection
November	Submit Contracts Division Service Request
November	Initiate Provider Selection Process
December	Select Providers

2006	
January	Negotiate Contracts
	Complete contracting process with Board approval
February	Providers recruit and hire staff
March	Program Fully Operational

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

T-03: TAY HOUSING

1) Complete Exhibit 4 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

There are three housing related systems development investments within the TAY budget and these investments apply primarily to youth ages 18-25.

- Motel vouchers for TAY who are homeless, living on the streets and in dire need of immediate shelter;
- Project-based residential sites for TAY who have been in long term institutional settings, e.g., level 14 group homes (including those TAY who could qualify for level 14 group homes, but were living elsewhere), hospitals, Institutes of Mental Disease, Community Treatment Facilities, jails and Probations camps; TAY who require structured settings and TAY who are experiencing their first psychotic break.
- A team of Housing Specialists, at least one for each Service Area, to develop local resources and help TAY find and move into affordable housing.

Housing provides a fundamental level of stability in which to help these young people achieve their goals of wellness and recovery. The lack of affordable housing options, including short-term, long-term, and permanent options, is a profound barrier for transition age youth who need support and services for recovery. Moreover, most of these individuals do not meet the federal government's definition of "chronic homelessness," and cannot qualify for many of the government subsidized programs that are now catering to this population.

The workgroup recommends the following investments:

1) **Motel/hotel vouchers for emergency housing.** In order to get young people off the street, it is recommended to employ motel vouchers as a form of emergency housing. One important principle in the use of these vouchers is that youth are provided with safe emergency options away from the environments in which they originally got into trouble. Once housed, youth may be assessed for mental health dysfunction and can elect to access mental health services and more permanent housing options. Each voucher has been valued at $70/night. Youth may be eligible to stay up to 20 nights if a mental health assessment process has been initiated. Vouchers can be dispersed from locally based Transitional Resource Centers and other appropriate sites.

2) **Operational subsidies linked to housing units.** This program will address the long-term housing needs of transition age youth within full service partnerships, some of who had previously been in structured, often institutional settings and now face homelessness. Other candidates will be emancipating from transitional housing programs or directly from foster care or group homes. Still others will be experiencing their first episode of a serious mental illness.

   Permanent and long-term investments in operational subsidies linked to specific residential sites are critical to meet and maintain permanent long-term housing for these high-risk youth who, with sufficient support, could live in the community. These are long-term investments that will be leveraged with other public and private funds to develop the permanent housing sites. A hard commitment of ongoing operational funds is required whenever a developer applies for State and federal government assistance to build or renovate new housing units. In fact, there are several projects in Los Angeles County that are on hold because of the lack of ongoing operational and service funds. The infusion of these MHSA funds will allow for the expedited development of new permanent housing stock to serve this population.

   The advantage of these long-term investments is that when a unit is vacated by a youth, the unit *remains available* for occupancy by other TAY with similar mental health needs. The operational subsidy stays with the unit, not with the individual, and thereby insures a permanent supply of housing for this hard-to-place population. Moreover, the rents remain stable over decades since the apartments are not in the competitive real estate market.

   The programs developed through this model will remain relatively small to provide for more active engagement with staff and will offer diverse, specialized and flexible services. Housing and services costs for these highest-risk youth are anticipated to be significantly higher than the average cost of $15,000 per FSPP participant, so the additional housing investment is leveraged from within the Systems Development allocation. One project will be focused on the highest risk youth that have spent significant time in an institutional setting or Level 14 group home. Three other programs will be initiated to house moderately high-risk youth in either master-leased apartments or a subsidized development. Each of the project-based programs be leveraged with FSPP dollars to cover the costs of services and non-housing supports that these youth require.

3) **Housing Specialists**: In December 2003, DMH commissioned a study of the federal rental subsidy programs administered by their Homeless and Housing Division in conjunction with the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA). The study revealed that far fewer than half of the consumers approved to receive a rental subsidy actually leased an apartment. This was largely because mental health staff lacked the time and resources needed to assist the consumers who faced multiple barriers to securing private market housing with their housing

search. Accordingly, it was recommended that the Department "needs to secure dedicated staff at least at the service planning area level to help successful voucher holders secure housing."

The Department's highly successful SHIA (Supportive Housing Initiative Act) program utilized housing specialists very effectively in the delivery of housing-related services to homeless clients in three areas in Los Angeles County: Long Beach, West Los Angeles/Santa Monica and the Metropolitan Area including downtown. Housing Specialists assist the clients to complete applications for rental subsidies, housing programs or private rental agreements. They prepare the members for the interview with a prospective property owner or housing manager as well as accompanying the member during their housing search. One of the major functions of a Housing Specialist is to act as an advocate and negotiator for members with poor credit and poor housing histories (i.e. evictions or lack of a housing tenancy whatsoever) while establishing a professional relationship with property owners and managers. For transitional age youth, it is particularly problematic to secure an apartment because they have little or no history of living independently.

A total of 9 new positions are proposed for Housing Specialists to be engaged with transition aged youth which would include eight Housing Specialists, one in each Service Planning Area, and a Housing Supervisor. These positions would coordinate their services with the TAY Specialists who will be located within Transitional Resource Centers (TRCs), youth drop-in centers or working within the probation and foster systems to assist youth with transition planning around their emancipation.

3) Describe any housing or employment services to be provided.

Described above.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

One of the most essential elements for the success of mental health services is a strong commitment to meet the permanent housing needs of young adults with mental illness. It is difficult, if not near impossible, to work toward recovery and wellness without living in a stable, affordable environment. But housing is not enough. It is difficult, if not near

impossible, to maintain living in a stable, affordable environment without supportive services. Both are needed in tandem with each other.

The program recommendations for housing contained in this proposal are aimed at providing the permanent and stable housing, along with supported services that are needed by transitional age youth to advance towards recovery, independence and self-sufficiency. Without these programs in place to break the cycle of recovery and relapse, these youth will remain in and out of homeless and continue to suffer with their mental illness.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Peer advocates, who are recovering transitional age youth, are an intrinsic part of the program at all levels. They will be employed wherever possible to provide outreach, engagement and support to young adults both in the emergency voucher program as well as in project based housing strategy.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Housing strategies for transitional age youth have been developed in collaboration with the stakeholders from the Adult and Older Adult Systems of Care. There is full consensus on the funding and organizational approaches that will be proposed by DMH for each of these populations. The project-based housing will require collaboration between housing developers, FSPP providers, lenders and other sources of capital financing, as well as service providers in the community surrounding the developments.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Since all program and expenditure plans recommended for funding under the CSS plan must demonstrate compliance with strategies for addressing the needs of culturally and linguistically diverse communities the Department will:

- Develop and implement programs that increase the system's capacity to recruit, hire, train and retain qualified bilingual-bicultural professionals, para-professionals, consumers and families for each aspect of the CSS plan. Every attempt will be made to ensure that the ethnicity and language capability of staff that is hired is reflective of the population that the program serves.
- Implement current culturally and linguistically appropriate strategies, policies and procedures to ensure access to culturally appropriate services for unserved, underserved and inappropriately served ethnic populations, with continuous improvement integrated.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Permanent housing requires a high degree of sensitivity in identifying an appropriate residential site. Staff will be thoroughly trained and supervised to work with a full range of diverse clientele. All program and expenditure plans funded under the CSS plan will be sensitive to and address issues of sexual orientation and the differing psychologies of males and females. It will address issues related to gender and sexual orientation by relying on evidence-based assessment, intervention and support strategies. Some examples include:

- Development of referral sources for appropriate housing options that provide for the array of sexual orientations and preferences; and
- Service Area and System Navigators that have knowledge of and access to services that are sensitive to the needs of clients who are gay, lesbian, bi-sexual, transgender or questioning.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The resources of these programs will be available to out-of-county individuals whou are residents of the County of Los Angeles and planning their return to the County.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

The separate timelines for the three components of TAY Housing are based on a projected program implementation date between March and June 2006. This will be

dependent on the funding allocation coming into the County during the month of January. This work plan calls for an October 2005 start date. The tasks to be accomplished are as follows:

HOUSING: Motel vouchers *(DMH operated)*

2005	
October	Begin Program Design, including identifying additional staffing needs
	Project Manager Selection
November	Develop policies and procedures

2006	
January	Recruit and hire staff (if directly operated program)
March	Program Fully Operational

HOUSING: Project-based Subsidies *(Contracted Process)*

2005	
October	Select task force members to write RFP for rental subsidies: DMH, CDC, Shelter Partnership
	Select housing review team
	Task force to write protocols/RFP/develop criteria for Provider Selection
November	Advertise / issue RFP
	Submit Contracts Division Service Request

2006	
January	Initiate Provider Selection Process
February	Select Providers
	Negotiate Contracts
	Develop Board Letter for contract approval
	Complete contracting process with Board approval
March	Program Fully Operational

HOUSING: Housing Specialists (if DMH-operated)

2005	
November	Begin Program Design/Planning Process, including staffing
	Develop job duty statements for Housing Specialists
	Initiate discussions with Housing Agencies and Resources
December	Develop policies and procedures
	Explore locations for staffing

2006	
February 2006	Select Program Supervisor
January 2006	Order S&S
March 2006	Recruit and hire staff (if directly-operated)
May 2006	Staff training
June 2006	Program Fully Operational

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County.

T-04: TAY Probation Services

1) Complete Exhibit 4 (as required under Section IV response). Using the format found in Exhibit 4, please provide the following summary:

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Services in the Probation Camps are critical in assisting this portion of the TAY population with mental health needs to reach their maximum potential rather than continue their involvement in the criminal justice system as adults. Due to a scarcity of funding and resources, the Probation Camps have not been adequately staffed with mental health workers to continue to care for those youth that have already been identified as requiring services. Additionally, some youth do not experience obvious difficulties until they are sentenced to the Camps. At that time, many of them require either emergency crisis services and/or other ongoing mental health supports.

DMH proposes to create multi-disciplinary teams inclusive of parent/peer (must be at least 18 years of age) advocates, clinicians, and Probation staff to provide a variety of treatment and support services. These services will include assessments for mental illness, co-occurring substance abuse issues, and medications; ongoing treatment services (individual, group, medication maintenance, substance abuse interventions and case management); peer support, parent support/education, behavior management, discharge planning including benefits establishment and transition planning with linkages back to the community and/or family – by linking youth who qualify to FSPPs which specialize in working with the Probation/gang involved population.

Background and Need

In Los Angeles County, mental health services are provided to youth that are in the custody of the Probation Department. These services are provided in three Juvenile Halls with an average overall daily population of 1,800 youth, and in 18 camps (plus the Dorothy Kirby Center) with an average overall daily population of 1,900 youth.

Youth are usually in the Halls due to involvement in criminal activity or awaiting suitable placements. Youth are sentenced to the Camps following charges being filed and upheld in Juvenile Court proceedings. The serious need for these services in Halls and Camps was revealed some time ago. However, resources to address these needs were siphoned off of the then existing budget for the Child and Family Bureau.

The population in the Halls ranges from 12-18 years old. Every effort is being made to divert youth 14 and under away from placements in the camps. As a result the population in the camps is 15-18 years old.

All of the youth that enter the Juvenile Halls are screened for specific risk factors that might signal the need for mental health services. Of the approximately 13,000 youth screened annually, almost 30% are in need of ongoing mental health services. These screenings also reveal that 70-80% of the youth are substance involved.

Due to critical incidents in the Juvenile Halls in the past, the U.S. Department of Justice (DOJ) has been monitoring those programs for approximately four years. There is currently a settlement agreement between Los Angeles County and DOJ that establishes the ground rules for the provision of specific services to these youth by Health Services (DHS), Mental Health (DMH), Probation, and LA County Office of Education (LACOE). Failure to comply could result in a Consent Decree. DOJ monitors and reviews these programs every six months, including interviews of youth and reviews of records.

Proposal for New Camp Services

Currently, efforts are needed to ensure that there is sufficient service capability in the Camps to address the needs of the youth there. The SED/SMI youth that are identified in the Halls require ongoing services in the Camps. CSS funding will provide a funding mechanism to develop a new program that will serve the needs of the youth that are sentenced to Camps in a comprehensive manner.

With mental health staff in the camps funded by MHSA dollars, more specialized program planning can be done for the youth that are housed there. In a joint planning effort with the Probation Department, services can be tailored to better meet the needs of the minors in the Campsites. This funding will enable us to hire parents and peer advocates to work with the youth prior to release.

Services will be provided by teams in a variety of the Probation campsites, and may be provided by contractors or directly operated employees or a combination of the two.

The array of services, aimed at transitioning youth out of the Probation settings, will be primarily clinical and strength-based in nature with a combination of assessment, ongoing treatment (group, individual, and family), and other collaborative services. Additionally, family and peer advocates will provide a range of educational and support services to the youth in the Camps and their families. Discharge planning and community linkage services will be critical components of the program. The bulk of this funding will be spent on personnel costs.

The staff identified in the budget spreadsheet will comprise three assessment and treatment teams. The Psychiatrist, the Psychologist, and the Mental Health Counselor, RN will be floaters that will be utilized by all three teams, based on the specific needs of the identified youth. The social workers and the advocates will form the basic core of the teams and will provide most of the case finding services. Their findings will be shared with the floater staff and comprehensive treatment plans will be developed. The Peer advocates will assist the social workers with monitoring the ongoing status of the youth on a day-to-day basis and alert them to any behavioral difficulties with tolerating the Camp routines. They will explore the feasibility of developing some self-help

groups, in an attempt to begin to teach self-reliance prior to release. The family advocates will establish contacts with the families, especially for those youth that will reside at home upon release. The teams will also ensure that there is coverage (on visiting days) to provide information to families and other caregivers and to answer questions about the Camp routines.

It is anticipated that the team approach will afford the staff an opportunity to adequately carry more cases at a time. The needs and levels of involvement will vary from minor to minor. These resources will allow for a comprehensive approach and management of the mental health care of youth in the Camps.

During the 2004-05 fiscal year, there were 1,604 unduplicated minors (of the 5,000 admitted) in the Camps with mental health issues/concerns. Approximately 480 (30%) had more serious concerns that required treatment/attention. It was impossible to provide treatment services to this population due to the scarcity of resources. With the determinant sentences (3, 6. 9 months) that the minors receive in the Camps, there is conceivably some movement approximately every three-six months. As a result, these treatment teams could easily carry caseloads of 60-70 minors each with additional youth/families served for less intensive needs that are very time limited.

There will be a need to quickly assess, with the Probation Department, space availability and suitability in the Camps for these additional employees. There may be a need to explore the feasibility of mobile units to house some of the personnel, if existing space is not available.

3) Describe any housing or employment services to be provided.

N/A. See TAY FSPP for linkage information.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

All services and activities are based on a recovery model/approach, which views mental illness as a condition from which an individual can recover and live a healthy and productive life. Interventions, from beginning to end, are framed in the context of youth participation, individual preferences/aptitudes, and joint goal setting activities with the staff/team assigned to them.

The proposed service components will use a strengths-based approach that quickly assesses and builds on individual values, mores, beliefs, and cultures. This approach to recovery from mental illness encourages and teaches youth how to actively participate in developing resiliency and coping skills that assist them with more comfortably tolerating rather than passively adjusting to situations that are often beyond their control. Services will emphasize self-care and wellness rather than illness, and encourage TAY to develop hope and realistic optimism about their futures, as adults.
Using the recovery model embraced by DMH, considerable emphasis will be placed on services that help youth in the Camps develop skills to more successfully cope with difficult situations and life crises. Practical skills and life planning activities such as arranging for a safe living situation after release from the Camp, determining and making plans to pursue career/vocational goals, and improving interpersonal skills are examples of potential service activities. Using peer and family advocates, the program will develop activities that enable these youth to develop the ability to identify and use community resources when they are released. Staff will provide assistance in benefits establishment for those who may qualify as one element of transition planning for return to the community. Through alcohol and drug education, discussion groups, and individual contacts, the program will attempt to reduce the abuse of substances.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

The Delegates and other local planning groups recognize the importance of involving both peers and parents to establish a true recovery model. This program will use multi-disciplinary teams that include parent/peer (must be at least 18 years of age) advocates. Their involvement in these teams helps to ensure that the services are client-centered, use a strengths-based approach, and take optimal advantage of peer support and influence.

In conjunction with Probation staff and mental health clinicians, clients and family members will be integrated into a variety of treatment and support services. Examples may include peer support groups and activities, parent support/education, and active involvement in discharge planning such as providing assistance with benefits establishment and transition planning with linkages back to the community and/or family. It is anticipated that each multi-disciplinary team will develop unique treatment activities that are tailored to the specific needs of the TAY population they serve, so specific services and/or support activities may vary from team to team.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population,

including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

This program plan has been developed through a collaborative effort with approximately 90 public and private partners that serve or have contact with TAY as well as parents, TAY consumer advocates and actual TAY consumers. The Juvenile Hall Probation Program has been a long-term collaboration between the County's Probation Department and DMH. This proposed program will broaden the collaboration to include the Department of Children and Family Services, Department of Health Services, and their Alcohol and Drug Program Administration to enable staff to develop more comprehensive programming as well as in-depth transition planning and linkages, when TAY return to the community. Additionally, the Public Defenders Office seeks to coordinate with DMH staff in the camps to obtain early release for SED youth who have been inappropriately placed.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Approximately 85% of all youth in Probation Camps are non-white. Thus, it is imperative that services be culturally competent and linguistically appropriate. Specific strategies include the following:

- Department will develop and implement programs that increase the system's capacity to recruit, hire, train and retain qualified bilingual-bicultural professionals, paraprofessionals, consumers and families for each aspect of the CSS plan. Every attempt will be made to ensure that the ethnicity and language capability of staff that is hired is reflective of the population that the program serves.
- Department will implement current culturally and linguistically appropriate strategies, policies and procedures to ensure access to culturally appropriate services for unserved, underserved and inappropriately served ethnic populations, with continuous improvement integrated.

All program and expenditure plans recommended for funding under the CSS plan must demonstrate compliance with the above strategies for addressing the needs of culturally and linguistically diverse communities, including TAY in Probation Camps.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

All program and expenditure plans funded under the CSS plan will be sensitive to and address issues of sexual orientation and the differing psychologies of males and females. It will address issues related to gender and sexual orientation by relying on

evidence-based assessment, intervention and support strategies. Some examples include:

- Development of referral sources for appropriate housing options that provide for the array of sexual orientations and preferences
- Service Area and System Navigators that have knowledge of and access to services that are sensitive to the needs of clients who are gay, lesbian, bi-sexual, transgender or questioning.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

No out of county services anticipated, as all Probation camps are located within county.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA. N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

The timeline for the Probation Camp services is based on a projected program implementation date as of March 1, 2006**.** This will be dependent on the funding allocation coming into the County during the month of January. This work plan calls for an October 1, 2005 start date, for the action steps needed to implement the program in March. The tasks to be accomplished are as follows:

2005	
November 2005	Begin Program Design/Planning Process
October 2005	Project Manager Selection
October 2005	Initiate discussions with Probation, DHS, and ADPA re: support services
November 2005	Develop policies and procedures
November 2005	Finalize staffing patterns
November 2005	Confirm space availability for additional staff in Camps
October 2005	Develop criteria for Provider Selection
November 2005	Submit Contracts Division Service Request
November 2005	Initiate Provider Selection Process
December 2005	Select Providers
2006	
January 2006	Negotiate Contracts
January 2006	Complete contracting process with Board approval
Jan/Feb 2006	Recruit and hire staff (if directly operated program)
February 2006	Develop staff training plan and schedule training (Mental Health and Probation)
March 2006	Program Fully Operational

We anticipate that this program design and planning process will take approximately 16 weeks to complete. With the holiday season, there will obviously be a slowdown and key personnel may not be continuously available. Despite the very aggressive schedule for completion of necessary tasks, it is hoped that implementation can occur as scheduled. The Project Manager will closely monitor the processes to ensure that the needed actions and tasks are proceeding accordingly. The contracting process will probably take the longest period of time to accomplish.

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles.

ADULT SYSTEMS DEVELOPMENT INVESTMENTS

A-02: WELLNESS/CLIENT RUN SUPPORT CENTERS

1) Complete Exhibit 4.

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Wellness/Client Run Support Centers are designed to offer options to clients who no longer need the intensive services offered by the FSP programs, who may be receiving services from less intensive outpatient programs, and who are ready to take increasing responsibility for their own wellness and recovery.

Ideally the Wellness/Client Run Support Centers will be located in their own buildings that are centrally located to many other community organizations, rather than as part of an outpatient clinic or FSP program site. Activities at the Centers will include scheduled appointments with the Nurse Practitioner or Psychiatrist for medication or physical health issues (Wellness Centers); participation in small self-help meetings and workshops; research or use of a small computer/resource library; and meetings/ interactions with other staff who work there. In addition, the Centers will need a "welcome area," where anyone entering can find peer support staff available for questions, concerns, or help with scheduling services. The environment is intentionally friendly, welcoming, and "non-institutional" in appearance. Larger workshops, self-help meetings, and planned social events are held at larger venues outside the Wellness/Client Run Support Centers.

The Wellness Centers address both mental and physical health, based on research showing that people with mental health issues also have a high incidence of serious physical health problems, including diabetes, hypertension and obesity, which can be side effects of medications. Wellness Centers offer a variety of support and strategies to its participants, addressing their physical and mental health needs. With the Wellness Recovery Action Plan (WRAP) at the core, there is an enormous emphasis on pro-active behavior, preventative strategies, and self-responsibility. The Wellness Center integrates this with mental and physical health education, self-help meetings, peer support, and medical and psychiatric support, in order to help program participants continue in their recovery and pursue their goals for a healthy life.

In the spirit of developing a community of inclusion, the Wellness/Client Run Support Centers welcome anyone in the community to participate in the variety of self-help, educational, and social/recreational activities they offer. These Centers are committed

to increasing the capacity of the community to include all citizens. Community development will be a critical component of the Centers' efforts because of the many benefits created by becoming active in the life of a community. Community development provides opportunities for individuals to develop non-institutional support mechanisms, reduce stigma, and decrease reliance on mental health and other related systems, all critical elements of success as individuals strengthen their self-reliance. Persons participating in these Centers need not be enrolled in a program and groups will be available to members of the public who would like to participate.

The Wellness/Client Run Support Centers will use Systems Development funds and Medi-Cal, Medicare and other available third party revenue, where appropriate.

3) Describe any housing or employment services to be provided.

This program will not directly provide housing or employment services but will refer and support clients in accessing programs that address housing and employment.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This program embodies the CSS plan's overarching theme of a commitment to recovery and wellness. The Wellness Centers focus is on teaching, modeling and providing activities that promote recovery and wellness basics, provided by peers, paraprofessionals, and professionals. Wellness/Client Run Support Center members will participate in all aspects of planning, program delivery and outcome evaluation.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This Systems Development investment is based on an existing strategy. DMH currently has two Wellness Centers under development and a variety of self-help groups, provided by such groups as the National Mental Health Association of Los Angeles' Project Return: The Next Step, SHARE, the Westside Center for Independent Living and other client-run organizations. Funding of Wellness Centers/Client Run Support Centers under the MHSA CSS will enable the development of additional Centers in strategic locations throughout the County, and Centers that focus on unserved/underserved populations, including ethnic minorities. This program is supported by the MHSA CSS: Three Year Program and Expenditure Plan requirement

(p. 3) that system improvements increase client participation and client-operated services.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Clients will manage and staff the Client Run Support Centers. Although the Wellness Centers will include professionals, clients will run these Centers as well. These collaborative efforts between clients and professionals can demonstrate that self-help and professional services can be complimentary by creating a culture that honors each individual's gifts, talents, and skills.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Wellness/Client Run Support Centers are open to members of the community at large, a strategy that will promote community involvement with the activities and members of the Centers and normalization of persons with mental illness. Stakeholder groups and Service Area Advisory Committees (SAAC) have supported this model because it is client-driven and provides vital supports for clients, including those who do not require intensive or traditional mental health services. Center staff and volunteers will work closely with the Service Area and Service Area Navigators, Residential and Bridging Services, Jail Transition and Linkage Services, FSPs, clinics, and other programs to develop coordination and flow within the system.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Wellness/Client Run Support Centers will serve all persons and groups within the community. Clients develop groups, which they run, thus the group reflects the unique cultural and linguistic character of their community and the differing psychologies and needs of men and women, including their sexual orientations. Attention will be given to developing Centers in areas with unserved/underserved ethnic minority populations that have been underrepresented by client run centers and services.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Wellness/Client Run Support Centers will serve all persons and groups within the community. Clients develop client-run groups in each community reflecting the unique cultural and linguistic character of the community and the differing psychologies and needs of men and women, including their sexual orientations. Attention will be given to developing Centers in areas with unserved/underserved ethnic minority populations that have been underrepresented by client run centers and services.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Although these Centers will not be established out-of-county, they will be open to clients residing out-of-county.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
September	Designate DMH lead manager
October 15	Determine approximate number of Centers to be opened, areas in which to locate the Centers
November 15	Develop provider selection process
December 2005	Select Community Based Organization (CBO) and DMH providers, subject to allocation of funding

2006	
	CBO providers:
February	Complete contracting process
March	Begin implementation
	DMH providers:
January	Obtain equipment & supplies
February	Obtain temporary space
March	Complete hiring and training process
	Begin implementation
	CBO & DMH providers:
April	Obtain Medi-Cal certification for Wellness Centers
June	Full implementation
December	Assessment of program and implementation of program refinements

2007	
December	Ongoing implementation, program assessment and program refinement

2008	
December	Ongoing implementation, program assessment and program refinement

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

A-03: IMD STEP-DOWN FACILITIES

1) Complete Exhibit 4.

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The IMD Step-down Facilities program provides supportive on-site mental health services and limited operational costs, when necessary, at selected licensed Adult Residential Facilities (ARF), and in some instances, assisted living, congregate housing or other independent living situations affiliated with the ARFs. The program will serve 50 to 100 individuals at any given time, 18 years of age and above, the majority of who are persons ready for discharge from Institutions for Mental Disease (IMD). The program will also accommodate persons being discharged from acute psychiatric inpatient units or intensive residential facilities, or at risk of being placed in these higher levels of care, who are appropriate for this service. The program will target those individuals in higher levels of care who require supportive mental health and supportive services to transition to stable community placement and prepare for more independent community living. Strategies and features of this Systems Development investment are:

- The anticipated length of stay will be two to six months for the ARFs and unlimited for clients in assisted living, congregate housing or other independent living situations.
- The program will have 24/7 capacities for emergencies and specialized programming.
- Staffing for these supportive residential programs will include licensed mental health professionals, mental health workers, certified drug and alcohol counselors, and family and peer support advocates.
- Available services will include individual and group treatment, medication support, crisis intervention, case management, vocational rehabilitation services, and, if necessary, operational costs for enhanced non-Medi-Cal-reimbursable staffing.
- Peer support and family involvement will be a primary focus of the program promoting community re-integration before discharge from the program. For example, there will be Project Return, a client-run self-help group with peer bridgers, and DMH peer support advocates and bridgers.
- The MHSA, Medi-Cal, Medicare, or other available third party revenue will support the program.
- Outcomes will be consistent with those outlined in the CSS plan.

Implementation of the program will assist clients from acute inpatient, institutional and intensive residential settings to safely reside in the community with mental health and supportive services.

3) Describe any housing or employment services to be provided.

This program will provide housing and the opportunity for residents to participate in outside employment programs. Prior to discharge from ARFs, residents will be linked to FSPs or other mental health providers that will address housing and employment on an ongoing basis.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This program supports the CSS plan's commitment to recovery and wellness. The program will provide initial and on-going training on recovery and wellness for its program participants, their families, peer advocates, and paraprofessional/professional staff. Staff's commitment to recovery and wellness, as well as knowledge of practical tools for putting this commitment into practice, will be regularly addressed during supervision and staff meetings. The program will utilize community self-help and peer advocacy resources as well as County peer advocates identified in the Residential and Bridging Services component to assist individuals with transitions to permanent housing and mental health services.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Peer advocates will serve as members of the Countywide Resource Management's multi-disciplinary team that monitors and promotes quality of care. In addition, peer advocates will:

- Provide self-help support groups within the ARFs prior to discharge to support individuals' transition to more independent community living.

- Facilitate client participation in developing service plans and goals.
- Provide members of the team with information regarding clients' progress in achieving their goals.
- Assist clients in developing community living skills and utilizing community resources.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

This program will collaborate with a variety of other stakeholders to ensure that individuals receive services that are specific to their needs. The program will collaborate with Countywide Resource Management, Service Area and System Navigators, institutional providers, FSPs, community peer support programs, mental health clinics, and others to ensure coordination of services that support wellness and recovery. The program also intends to collaborate with other stakeholders such as Alcohol and Drug Program providers and the County's Asian-Pacific Alliance to meet specific needs of program participants.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Stakeholders have acted to ensure that every aspect of services included in the CSS plan will be culturally competent and will meet the needs of culturally and linguistically diverse communities. Strategies to be used include the following:

- Planning in each community for the IMD Step-down programs will include the involvement of consumers that are reflective of each community's underserved ethnic groups.
- Partnerships with providers that have ties to ethnic communities will be developed.
- Culturally and linguistically appropriate policies and procedures will be developed to ensure culturally appropriate services for unserved, underserved and inappropriately served ethnic populations.
- Departmental benchmarks will be established and utilized to ensure that the IMD Step-down programs achieve the requisite level of service to underserved minority populations.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The IMD Step-down program will be sensitive to and address issues of sexual orientation and the differing psychologies of men and women by relying on evidence-based assessment, intervention and support strategies. For example, the program will also seek to develop appropriate housing options that provide for a variety of sexual orientations and preferences.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The program will provide services for clients who meet admission criteria from State Hospitals outside of Los Angeles County. The Department intends to explore the possibility of developing an ASL program at one of these facilities for hearing-impaired individuals currently in an out-of-county IMD. The program will also be available to out-of-county forensic clients currently in State Hospitals after their legal status has changed to LPS conservatorship and after stabilization in County IMDs.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA. N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
September	Designate DMH lead manager
October 15	Determine approximate number and location of facilities
November 15	Develop provider selection process
December 2005	Select providers, subject to allocation of funding

2006	
February	Complete contracting process
March	Begin implementation
March	Obtain Medi-Cal certification
April	Initiation of client-run groups at the facilities
May	Program quality of care review, identification problems and development of corrective action plan
June	Full implementation
December	Assessment of program and implementation of program refinements

2007	
December	Ongoing implementation, program assessment, and program refinement
December	Development of American Sign Language (ASL) program at a selected facility

2008	
December	Development of capacity to serve former forensic clients at a selected facility(ies)
December	Ongoing implementation, program assessment, and program refinement

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

A-04: ADULT HOUSING SERVICES

1) Complete Exhibit 4.

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Housing Systems Development initiative is designed to fund housing specialists throughout the County, and the service and operational costs of two new residential programs, Safe Havens, for homeless persons who have mental illness with co-occurring substance abuse disorders.

Housing Specialists: The Department's successful Integrated Services for the Homeless Mentally Ill program, AB 2034, has utilized housing specialists effectively in the delivery of housing services to its homeless members. The AB 2034 program has substantiated that housing specialists are extremely effective in securing and retaining private market rate housing for homeless individuals with mental illness. Accordingly, the housing specialists funded through the MHSA will adopt the model of service delivery employed by the AB 2034 Program. The housing specialists' functions will include, but not be limited to:

- Assisting individuals complete applications for rental subsidies and move-in assistance, housing programs or private rental agreements
- Assisting individuals to prepare for interviews with prospective property owners or housing managers
- Accompanying and assisting individuals with housing searches
- Acting as an advocate and negotiator for individuals with poor credit and poor housing histories (i.e. evictions or lack of a housing tenancy) while establishing a professional relationship with property owners and managers
- Averting possible evictions by maintaining a professional relationship and promptly addressing the concerns of the property owners and managers that may arise
- Working closely with individuals' PSCs or outpatient clinicians to assist with housing retention efforts and facilitate communication among the involved parties

In keeping with the Department's system transformation efforts, Housing Specialists will provide housing placement services not only for homeless individuals and families, but also those living in institutional settings, ARFs, Sober Living Homes and other community placements that seek to live in a more independent living situation. Assistance will also be given to those who are living in temporary, often overcrowded, situations with family or friends.

It is the goal of this program to have two Housing Specialists in each of the Department's eight Service Areas (SA). Currently, there are two existing Housing Specialists, one in SA 5 and one in SA 8. Accordingly, MHSA funding will be used for 14 new Housing Specialist positions for adults and older adults. Recognizing that each SA has unique characteristics and needs, the SA has the discretion to utilize a staffing pattern that is consistent with the needs of its particular area, including the recruitment of clients and/or family members.

Development of Residential Programs for the Homeless Mentally Ill/ Safe Havens: Safe Havens provide a safe and non-threatening environment for chronically homeless individuals with mental illness and possible co-occurring substance abuse disorder to seek refuge. Each program will provide a 24-hour staffed facility offering up to 25 semi-private accommodations for men and women for an indefinite period. The programs are intentionally kept small, to provide for more intimacy and opportunity to engage with residents, and embrace a high-tolerance, low-demand service philosophy. Due to the high levels of disability among the targeted population, the programs offer diverse, specialized services that are flexible to address the non-linear progression of mental illness and substance addiction. Accordingly, staffing for these programs will include individuals with similar backgrounds and experiences as those individuals being outreached. Specifically, staffing will include clients and family members who have experienced homelessness and/or substance abuse. The capacity and configuration of the Safe Havens will depend heavily on the site, as some programs also provide supportive services on a drop-in basis to eligible persons who are not residents. From a housing perspective, these programs are focused on preparing and moving clients into more appropriate forms of support, such as Shelter Plus Care, where they can benefit from permanent supportive housing. Safe Haven residents can stay indefinitely, although many move on within six months.

3) Describe any housing or employment services to be provided.

These programs will directly provide housing and referral to employment services.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

These programs embody the recovery and wellness values by recommending the recruitment of qualified clients, formerly homeless individuals, and family members for outreaching and engagement activities, and assisting individual and families secure and retain permanent housing. In addition, the programs empower individuals by offering

necessary systemic supports for community re-integration, allowing placement in the least restrictive community setting of their choice and assisting with approaching landlords, moving into housing, and learning skills necessary to maintain housing.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This program is basically a new initiative. The initiative will fund service and operational costs for two new Safe Havens, modeled after the two currently in operation in Los Angeles County. In addition, the Housing Program will provide 14 new Housing Specialists, thus initiating services in six of the Department's eight SAs, and supplementing services in the other two SAs. In relation to the Housing Specialist component, implementation of this program will promote system change and a transformation of the current service delivery system regarding securing permanent housing. In December 2003, DMH commissioned a study of the federal rental subsidy programs administered by its Homeless and Housing Division in conjunction with the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA). The study revealed that less than half of the clients approved to receive a rental subsidy actually leased an apartment. This was largely because mental health staff lacked the time and resources needed to assist clients who faced multiple barriers to securing private market housing with their housing searches. Accordingly, it was recommended that the DMH "secure dedicated staff at least at the service planning area level to help successful voucher holders secure housing." [5]

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

This program advocates for the employment of clients and family members in each component. It is recommended that clients and/or family members function as part of SA Housing Teams as employed Specialists or as volunteers to assist in identifying property owners and managers willing to rent to individuals with mental illness. In addition, the Safe Haven model employs former homeless individuals and individuals in recovery to function as community outreach workers or as part of the case management staff of the facility.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The Housing Specialists will be expected to develop professional relationships with professional housing associations and community groups. The Safe Havens will be expected to collaborate with many community agencies/groups such as law enforcement, business associations, and residential and drug and alcohol program providers.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The Housing Specialists will be encouraged through training and supervision to be aware of the needs of culturally and linguistically diverse clients in their areas and to develop housing resources that meet those needs. They will be expected to collaborate with organizations that represent these diverse communities and solicit their expertise in meeting the needs of the communities they represent.

The providers of Safe Havens will also be expected to make training available to their staff and to develop policies and procedures that rely on evidence-based assessment, intervention and support strategies to accommodate culturally and linguistically diverse clients and persons with non-traditional sexual orientations and the differing psychologies and needs of women and men.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

An approach similar to that described in section 9 above will be taken to accommodate the needs of persons with non-traditional sexual orientations and the differing psychologies and needs of women and men.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The resources of these programs will be available to out-of-county individuals who are residents of Los Angeles County and planning their return to the County.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

Housing Specialists:

2005

September	Designate DMH lead manager
November 15	Develop provider selection process
December	Select providers, subject to allocation of funding

2006

If CBO provider(s):	
February	Complete contracting process
March	Begin implementation
If DMH:	
January	Obtain equipment & supplies
February	Obtain temporary space
March	Complete hiring and training process
	Begin implementation
	Participation on Service Area Administrative and/or Housing Team
June	Full implementation
December	Assessment of program and implementation of program refinements

2007

December	Ongoing implementation, program assessment and refinement

2008

December 2008	Ongoing implementation, program assessment, and program refinement

Safe Havens

2005

September	Designate DMH lead manager
December	Develop provider selection process

2006

February	Select providers
April	Complete contracting process, Begin implementation of contract to provide service and operational costs Contingent upon completion of development of the facilities

2007

December	Ongoing implementation, program assessment, and program refinement

2008

December	Ongoing implementation, program assessment, and program refinement

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

A-05: JAIL TRANSITION AND LINKAGE SERVICES

1) Complete Exhibit 4.

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Jail Transition and Linkage Services are designed to outreach and engage/enroll incarcerated individuals receiving services from Jail Mental Health Service or others with mental illness referred by Mental Health Court Workers, Attorneys, and family members, into appropriate levels of mental health services and supports, including housing and employment services, prior to their release from jail. The goal of these services is to prevent release to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services. A Linkage and Engagement Team will identify those individuals who meet the criteria for FSP programs and coordinate the referral and linkage with FSP programs. For those individuals requiring assistance but not meeting the criteria for FSP, the team will link the individuals with a Service Area Navigator and/or appropriate program(s). Individuals interested in seeking employment, including those being referred to FSP programs and those linked with a Service Area Navigator will be referred to one of four designated partner WorkSource Centers administered by the City of Los Angeles Community Development Department.

The Linkage Team will interview and assess referred clients to determine level and type of need, develop a release plan, coordinate with Service Area and Service Area Navigators or FSP programs for appropriate placement, and refer to one of the designated WorkSource Centers, when indicated. All Linkage services will take place while the client is incarcerated, thus ensuring a seamless transition from jail mental health services to community based services upon release.

The Jail Linkage and Engagement Team will also be responsible for following clients who are referred to and placed in a DMH Specialized Shelter Program upon their release from jail. The team will work towards transitioning these individuals from the Specialized Shelter to enrollment in a FSP program.

We estimate that, currently, approximately 77 inmates being released from the jail each week need linkage to MHSA community-based services. In order to serve this volume of inmates, the Jail Linkage and Engagement Team will consist of a multi-disciplinary team of professional, paraprofessional, and support staff that will report directly to the County Resource Management District Chief. The professional and paraprofessional

staff will be assigned to each SA and will work in collaboration with the Jail Mental Health Staff assigned to the same SA.

The Rehabilitation Counselors on the Jail Linkage and Engagement Team will be assigned to two SAs each and will work in collaboration with the Jail Mental Health Staff assigned to the corresponding SA. In addition, the Rehabilitation Counselors will be co-located regularly at the four designated partner WorkSource Centers in order to coordinate the transition from jail to the community.

The Rehabilitation Counselors will provide the employment component of the Jail Transition and Linkage Services. They will provide the follow tasks:

- Co-locate at a designated WorkSource Center 3 to 4 days a week providing a full complement of services (clinical, employment and case management)
- Meet with DMH clients initially engaged in the jail and those referred from FSP programs at the WorkSource center.
- Participate in co-case management of DMH clients with WorkSource center staff.
- Participate in WorkSource Center Orientation, presenting on mental health services available to WorkSource customers
- Provide referrals for WorkSource customers to appropriate mental health or substance dependence services.
- Provide training to WorkSource Center staff and partner staff on identified topics relating to mental health such as conflict resolution, stress management.
- Include WorkSource Center staff and interested partners in any appropriate training opportunities provided by the County Department of Mental Health or its partner agencies

3) Describe any housing or employment services to be provided.

This program will refer to outpatient programs, such as FSPs, that will provide housing and employment services. Linkage Team members will also, in some instances arrange temporary, short-term housing such as hotel vouchers potentially provided by the Department of Public Social Services, or DMH Specialized Shelter Beds. As previously noted, those individuals who express a desire to seek employment will be referred to one of four designated WorkSource Centers. The Rehabilitation Counselor assigned to the Jail Linkage and Engagement Team will interview individuals while in jail and personally direct them through the enrollment process at the WorkSource Center.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for

adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The purpose of the Jail Linkage and Engagement Team is to prevent clients being discharged to the streets of Los Angeles. By receiving linkage services, clients will be able to take advantage of recovery focused community services, including FSP programs and employment services. The service delivery system for the employment component of the Jail Linkage and Engagement is consistent with the characteristics of the evidenced-based practices of Supportive Employment such as:

- Consumer choice,
- Competitive employment,
- Employment is integrated with treatment,
- Job search is immediate,
- Retention services are continuous and
- Consumer preferences are valued.

Los Angeles County is well positioned to operationalize a commitment to recovery, with an Office of Consumer and Family Affairs within the Department, as well as a solid, experienced base of self-help organizations.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Models for increased levels of participation and involvement of clients and families have been developed, such as Project Return and peer-run discharge preparation groups in Institutions for Mental Disease and Adult Residential Facilities. This program will explore the possibility of having peer advocates/bridgers participate in release preparation groups provided by Jail Mental Health staff and/or the Jail Transition Team.

The Department promotes the recruitment and employment of consumers and family members as part of FSP teams or specialized employment teams that focus on job placement and retention.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The Jail Linkage and Engagement Team will collaborate with the Los Angeles County Sheriffs Department, Probation, Mental Health Court Workers Program, client attorneys and families. In addition, the Department will collaborate with the City of Los Angeles Community Development Department to co-locate DMH staff at the four designated partner WorkSource Centers. These collaborative relationships will offer the courts alternatives to jail/prison sentences, provide needed mental health services, reduce recidivism and increase clients' ability to further their recovery.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The Jail Linkage and Engagement Team will include individuals who are qualified bilingual-bicultural professionals and paraprofessionals. Culturally and linguistically appropriate strategies, policies and procedures will be developed to ensure access to culturally appropriate services for unserved, underserved and inappropriately served ethnic populations.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

The Jail Linkage and Engagement Team will be sensitive to and address issues of sexual orientation and the differing psychologies of men and women. Linkage Team staff will be expected to develop and utilize policy and procedures based on evidence-based assessment, intervention and support strategies. Some examples include:

- Team members that have knowledge of and access to services that are sensitive to the needs of clients who are gay or transgender
- Referral to programs and services that provide for an array of sexual orientations and preferences

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

N/A

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
September	Designate DMH lead manager
November 15	Develop provider selection process
December	Select providers, subject to allocation of funding
	If CBO provider(s):
2006	
February	Complete contracting process
	If DMH:
January	Obtain equipment & supplies
February	Obtain temporary space
March	Complete hiring and training process
	If CBO provider(s) or DMH:
	Begin implementation, including case management services for clients referred to a Specialized Shelter program
April	Establish Partnership with WorkSource Centers and initiate services at the Centers
April	Develop hotel voucher program for indigent inmates upon their release from jail, if feasible
June	Full implementation
December	Assessment of program and implementation of refinements
2007-2008	
	Ongoing implementation, program assessment, and refinement

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

OLDER ADULT SYSTEMS DEVELOPMENT INVESTMENTS

OA-02: Transformation Design Team

1) Complete Exhibit 4 (as required under Section IV response).

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Transformation Design team intends to utilize Community Services and Supports funding to transform the Older Adult (OA) System of Care in Los Angeles County. "Transformation Design" dollars will be used to identify, disseminate and evaluate values-driven, evidence-based and promising clinical services for older adults. The ability to promulgate and evaluate emerging practices is particularly critical in Los Angeles County, which is known for the rich cultural, ethnic and linguistic diversity of our population. It is an area where promising culturally relevant practices may evolve based on the wisdom and experience of clinicians, peers, family members and alternative/indigenous caregivers. The Transformation Design component of the CSS plan will create an opportunity to identify and develop promising practices, supporting those who may have knowledge based on experience – but who may lack the ability to objectively evaluate the success of their approaches.

The CSS Transformation Design program will focus on practices that are transformative and consistent with priorities identified in the State's CSS plan. Some examples include:

- Recovery-oriented approaches specific to older adults, including employment, volunteerism, and continuing education programs
- Evidence-based integrated treatment of co-occurring disorders in older adults – including new programs that will be developed due to changing patterns of substance abuse and mental illness stemming from the aging of the "baby boomers"
- Culturally sensitive evidence-based or promising practices for assessing and treating older adults, including assessment strategies that integrate primary healthcare providers in the treatment team
- Use of community based, culturally sensitive older adult family and peer support in the delivery of services which includes the following: peer advocates, peer counselors, family members, and alternative / indigenous caregivers
- Best practices for transition age adults including training and consultation services for adult providers working with transition age adults who will "age in place" within the adult system of care, as well as development of integrated

transition programs that will assist adults as they move from ASOC into OASOC programs.

The opportunity to transform the Older Adult System of Care in Los Angeles County comes at a crucial moment. Currently, the continuum of care is comprised of one countywide assessment team and five specialized contract providers serving older adults. Specialized treatment services for this age group are located in only three of the County's eight Service Areas with general services located in another two Service Areas. While the Department has focused on developing core staff competencies in assessment and treatment of older adults, recent professional and social changes are dramatically impacting the field. More specifically, the rapid expansion of evidence-based practices and the significant changes in the cohort of individuals entering the older adult age group (due to the baby boomer generation who are now reaching the age of 60) necessitate changes in program development and outcome monitoring as a basis for Community Services and Supports. The Transformation Design strategies proposed are intended to benefit two subgroups identified within the older adult group: individuals 60-64 years of age, and those who are 65 and older. In addition, proposed services will focus on the highly specialized needs of individuals over the age of 75 – a group that is growing dramatically.

In order to accomplish these goals, individuals with expertise in design, development and evaluation of programs for older adults will be recruited. Additional dollars will be used to retain the services of consultants with specialized expertise such as suicide among the elderly, psychopharmacology and aging, and integrated treatment of co-occurring disorders in older adults. Staff will develop baseline information about existing services and needs, identify evidence-based or promising practices, and evaluate the success of strategies that are implemented. Additional input will be garnered from peer and family advocates.

The proposed Transformation Design investment is expected to reach well beyond programs implemented through the Mental Health Services Act. The work of the Transformation Design program will impact older adult services with existing funding sources – thereby significantly leveraging resources available through the Mental Health Services Act.

3) Describe any housing or employment services to be provided.

For older adults with mental illness, the current array of housing options and supports for remaining in preferred housing is extremely limited. Older Adult Transformation Design dollars will be used to identify, disseminate and support emerging promising practices with the goal of expanding the array of appropriate housing options for this age group. In addition, strategies for supporting older adults in the least restrictive setting will be enhanced (e.g., new approaches to hoarding behavior).

Development of employment services has traditionally been the province of the adult system of care. With the expansion of numbers of transition age adults and older adults

with mental illness who have returned to work, there will be an increasing need for development of alternatives for aging clients who wish to continue some form of employment past the age of 65. In addition, embracing a recovery approach will require the development of new models for the meaningful use of time for older adults – within the world of work, volunteerism and older adult education. These approaches will be identified and developed by the OA Transformation design component of the MHSA plan for Los Angeles County.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Transformation Design efforts will ensure that all programs funded through the CSS portion of the Mental Health Services Act embody a wellness and recovery philosophy. Ensuring the recovery philosophy is at the core of all programming will be done through a variety of strategies including staffing (see the "Service Extenders" line item), Training (see the "Training" line item) and Program Development. As indicated above, new models will be developed and disseminated regarding the meaningful use of time for older adults, including work, volunteerism and older adult education. Integration with physical healthcare providers will also focus on a recovery and wellness orientation.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

As described above, there is much work to be done in developing a true continuum of services for older adults in Los Angeles County. The OA Transformation Design component of the CSS plan will ensure the ability to generate and analyze essential basic data regarding older adults with mental illness as well as develop and evaluate the field-capable clinical programs to be developed for this population with CSS dollars. This capacity does not currently exist.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Clients and family members will be included in the OA Transformation Design planning and oversight efforts. They will be recruited from the Office of Consumer Affairs, Office of the Family Advocate, and other community based client groups.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

This program will build on collaborations that have been or are in the process of being established. For example, partnerships are underway with the City and County Department of Aging, local universities, senior peer counseling programs, Multi Service Senior Programs, Senior Centers, County Adult Protective Services and other entities.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Stakeholders have acted to ensure that every aspect of services included in the Community Supports and Services plan will be culturally competent and will meet the needs of culturally and linguistically diverse communities. Strategies to be used for all older adult programs include the following:

- Dedicated funding will be allocated to ethnic populations who are uninsured and uninsurable, consistent with the language and cultural needs of each community. Benchmarks are being established and will be monitored to ensure that programs funded through MHSA CSS dollars achieve the requisite level of service to underserved ethnic minority populations.
- The number of community-based organizations that have ties to ethnic communities will be expanded and partnerships with providers that have such community ties will be strengthened.
- Planning in each community will include the involvement of consumers that are reflective of each community's underserved ethnic groups
- The Department will develop and implement programs that increase the system's capacity to recruit, hire, train and retain qualified bilingual-bicultural professionals, paraprofessionals, consumers and families for each aspect of the Older Adult CSS plan.
- Culturally and linguistically appropriate strategies, policies and procedures will be developed to ensure access to culturally appropriate services for unserved, underserved and inappropriately served ethnic populations.

All program and expenditure plans recommended for funding under the Older Adult CSS plan must demonstrate compliance with the above strategies for addressing the needs of culturally and linguistically diverse communities.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

All program and expenditure plans funded under the Older Adult CSS plan will be sensitive to and address issues of sexual orientation and the differing psychologies of men and women. Programs will be expected to address issues related to gender and sexual orientation by relying on evidence-based assessment, intervention and support strategies. Some examples include:

- The development of appropriate housing options that provide for the array of sexual orientations and preferences.
- Older adult service providers who are cognizant of the differing rates of suicide among men and women – and who are competent to assess and intervene with men and women at risk of suicide.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

N/A

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

The proposed Older Adult Transformation Design program supports the establishment of values-driven, evidence-based and promising clinical services that support client-selected goals as recommended in the State CSS plan. Transformation design dollars will enable Los Angeles County to identify, promulgate and evaluate promising approaches that are most culturally appropriate for our diverse population.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Older Adult CSS Plan: Transformation Design – Year 1
2005

October	Design Program, including staffing
November	Develop Job Announcement
	Develop Duty Statements
	Obtain HR Employment Placement Lists
December	Conduct Interviews
	Develop Policies and Procedures

2006	
January	Submit PAFs
	Order Equipment, Furniture, Office Supplies
	Order Telephones, Computers, Network Access
	Order Cell Phones, Pagers, Calling Cards
	Install Office Equipment and Computers
February	Fully Staffed
March	Program Fully Operational

Older Adult CSS Plan: Transformation Design - Year 2

2007	
Ongoing	Continue identification of evidence-based practices
Ongoing	Collect interim data and make adjustments to models and best practices
June	Produce first annual report of program results

Older Adult CSS Plan: Transformation Design – Year 3

2008	
Ongoing	Continue identification of evidence-based practices
Ongoing	Collect interim data for making adjustments to models and best practices
June	Produce second annual report of program results

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

OA-03: Field-capable clinical services

1) Complete Exhibit 4(as required under Section IV response).

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Development of field capable clinical services throughout Los Angeles County is a priority for the Older Adult System of Care. As noted above, specialized treatment services for older adults and their families currently exist in only three of eight Service Areas, with general services provided in another two service areas. Field capable services, delivered by interdisciplinary teams of professionals trained to work with older adults, will be offered in community locations preferred by the client including homes, senior/public housing complexes, senior centers, mental health clinics and primary care physicians' offices. Specific services include:

- Outreach and engagement
- Bio-psychosocial assessment
- Individual and family treatment
- Medication support
- Linkage and case management support
- Specialized treatment for Co-occurring disorders
- Peer counseling, family education and support

Field capable clinical service teams will also include consultation by gero-psychiatrists, geriatricians, gero-pharmacists, and neuro-psychologists. Field capable clinical service teams will coordinate care with available older adult appropriate psychiatric emergency services and conservatorship support (both LPS and probate).

Field-capable clinical services will address the needs of older adults who are between the ages of 60 and 64, and those who are 65 years and older. As the program develops, specialized services for those who are over the age of 75 will also become a focus. Stakeholders recommend the funding of field capable clinical services as they are currently unavailable in many areas within Los Angeles County. In addition, expansion of services to older adults will prioritize the needs of those who have traditionally been unserved or underserved. This includes those clients who need much engagement to access and maintain services (e.g. paranoid individuals who are fearful of "the system") individuals who are severely mentally ill and/or isolated, self neglecting or abused, and older adults who are homeless. Finally, field capable clinical services staff will focus on individuals who are uninsured, undocumented immigrants and/or monolingual in a language other than English. Additional sources of funding for this program will include MediCal and Medicare.

In contrast to many existing programs that are primarily clinic-based, field capable clinical services funded through the MHSA, will be dedicated to ensuring that services are provided in locations preferred by clients. This will include, for example, the option of co-locating services with physical healthcare providers – or delivering services in collaboration with primary medical providers.

3) Describe any housing or employment services to be provided.

Housing services for clients enrolled in field capable clinical services programs will offered in two ways. Permanent housing options, developed under the Adult System of Care Housing plan may be accessed by teams working with older adults. In addition, the Older Adult System of Care field-capable services program will provide support for individuals in their preferred independent and semi-independent housing situations, assisting clients who wish to remain as independent as possible. This will be accomplished by offering assessment and treatment interventions in home settings, facilitating delivery of meals and other supports, assisting with remediation of hoarding problems and providing linkages to in-home health care when appropriate.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Field based clinical teams will embrace a recovery approach for older adults. Teams will include service extenders (e.g., peer counselors and family advocates); all team members will be trained in the recovery model. As noted in the Transformation Design Team section above, field capable clinical teams will be expected to assist clients in meeting their recovery goals, including those related to the development of a meaningful use of time. Opportunities for employment, volunteerism, and older adult continuing education will be identified. Assistance with co-occurring substance abuse and physical health problems will be provided to ensure maximum wellness and healthy aging.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Currently countywide field capable services are limited to assessments and do not include clinical services. As mentioned above, field-capable clinical services are offered in limited areas of Los Angeles County. Under this proposal, the full range of clinical

services in collaboration with physical health providers will become available in all service areas.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

An essential component of the CSS plan for older adults is the involvement of "service extenders" on clinical teams. Through the "service extenders" program, family members and clients serve as peer counselors, peer bridgers, and support group leaders for families, caregivers and clients. These services will be provided through the multidisciplinary team (see service extenders section).

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The planning and implementation of the program will involve expansion of the existing collaboration with older adults service providers (e.g. mental health agencies, multi-service senior programs, social services organizations, and medical providers), first responders, law, safety and code enforcement, public guardian, adult protective services, faith-based organizations, consumers, family members, caregivers, allied professionals, universities, professional organizations, training institutions, other county departments, in addition to the Department of Mental Health central and geographic operations.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Field capable clinical services will be provided by culturally sensitive and linguistically competent staff. Dedicated efforts will be made to recruit staff from the communities they will serve. Service extenders – peers and family members – will also be drawn from the local community in order to maximize the availability of bilingual/bicultural staff.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

All field-capable clinical services will be sensitive to and address issues of sexual orientation and the differing psychologies of men and women. Programs will be expected to address issues related to gender and sexual orientation by relying on

evidence-based assessment, intervention and support strategies. Some examples include:

- Recognition of the need to access appropriate housing options that provide for the array of sexual orientations and preferences.
- Staff who are knowledgeable about the differing rates of suicide among men and women – and who are competent to assess and intervene by providing interventions that are sensitive to the differences between genders.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

N/A

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

Older Adult CSS Plan: Field Capable Clinical Services – Year 1

2005	
October	Design Program, including staffing
	Develop Criteria for Provider Selection
November	Initiate Provider Selection Process
December	Select Providers

2006	
January	Negotiate Contracts
February	Complete contracting process with Board approval
	Develop Training Plan
	Providers recruit and hire staff
March	Begin Site Medi-Cal Certification Procedure
	Secure Medi-Cal Certification
April	Program Fully Operational

Older Adult CSS Plan: Field Capable Clinical Services – Year 2
2006

Ongoing	Continue interdisciplinary team meetings
Ongoing	Continue collaboration with primary care
Ongoing	Continue enrollment of clients
June	Evaluate effectiveness of field sites

Older Adult CSS Plan: Field Capable Clinical Services – Year 3
2007

Ongoing	Continue interdisciplinary team meetings
Ongoing	Continue collaboration with primary care
Ongoing	Continue enrollment of clients
June	Evaluate effectiveness of field sites

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

OA-04: Service Extenders

1) Complete Exhibit 4(as required under Section IV response).

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Reaching older adults in a manner that is sensitive to their needs and culture includes providing services in homes, residential facilities and other community locations. Each Service Extenders program will recruit paid and/or volunteer peer counselors and family members who will address concerns for older adults and their families including:

- Isolation of the home-bound elderly
- Loss of support system due to the death and disability of family and peers
- Disorientation and cognitive decline that occur when older adults must navigate the movement between levels of care and institutions (as when an older adult is hospitalized or must enter a skilled nursing facility or assisted living center)
- Difficulties for family members who require mental health information and emotional support to cope with the changing circumstances of their loved one(s)

Assistance for family members will help reduce their stress level, and will also help ensure that they stay connected and in relationship with the client.

Service extenders are included within the Older Adult Community Services and Supports plan. The following components of the Service Extender Program are designed to address the needs outlined above:

- Peer Counselors/peer bridgers who are part of field-based clinical teams, will be hired to visit older adults in their residences. They will provide support and counseling, helping to reduce isolation. Peer counselors will also be trained to identify and intervene with older adults who are at risk of abuse, neglect or disability, thereby increasing the safety net for those who are most vulnerable. Peer counselors/peer bridgers will also support and assist older adults who are transitioning to and from hospitals and other residential facilities (e.g., returning home from hospital). As members of field-based clinical teams, they will provide continuous support, helping the older adult adjust to new settings and establish or reestablish linkages with individuals and services.
- Volunteer peer counselor programs may be developed by specialized older adult agencies. Staff will be hired to train, monitor and supervise volunteer peer counselors for these specialized programs.
- Family members who have life experience supporting older adults with mental illness will be trained to provide education and support groups for others.

All components of the Service Extenders program will address the needs of distinct groups of older adult mental health consumers and their families:

- those who are 60 through 64 years of age;
- those who are between 65 and 84 years of age; and
- those who are above the age of 85.

3) Describe any housing or employment services to be provided.

Service extenders will provide support for older adults who are in independent living. They will identify conditions such as hoarding, abuse and neglect that could jeopardize the living arrangement of older adult mental health consumers. Service extenders will bring these issues to the attention of the mental health multi-disciplinary team for resolution**.**

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Programs funded through the Community Services and Supports portion of the Mental Health Services Act will embody a wellness and recovery philosophy. Service extenders will exemplify a recovery approach since, by definition, they will be clients in recovery. They are expected to convey a sense of hopefulness and to serve as models for clients whose journey to wellness is just beginning.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

While there is only one general older adult peer counseling program in Los Angeles County, no specialized mental health peer counseling/peer bridging or family self-help/education programs currently exist that address specific cultural and mental health needs of older adults.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

The Service Extender Program is intended to retain paid and volunteer consumers and family members to serve as peer counselors/peer bridgers/family support counselors. They will participate as members of interdisciplinary teams.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Older Adult Service Extenders will collaborate with the full array of social and health programs for the elderly.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Service Extenders will be recruited from the community in which they will serve. They will be representative of the ethnic and linguistic characteristics of their local community. Specialized strategies that have been demonstrated effective with ethnic populations – such as the Promotoras model – may be utilized in developing this program.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Training for Older Adult Service Extenders will include issues related to sexual orientation and the differing psychologies of men and women. As they will reflect the older adult population, Service Extenders will likely have personal experience regarding changing self-concepts for older adults, including challenges to sexual role mastery and relationships that occur as individuals age. Since Service Extenders will meet clients in their homes, hospitals and other community settings, they will receive close supervision and engage in active discussions regarding the differing needs and resources of men and women as they age.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

N/A

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

Older Adult CSS Plan: Service Extenders – Year 1

2005	
October	Design Program, including staffing
	Develop Criteria for Provider Selection
November	Initiate Provider Selection Process
December	Select Provider
	Develop Policies and Procedures

2006	
January	Negotiate Contracts
February	Complete contracting process
	Providers recruit and hire staff
March	Train staff
April	Program Fully Operational

Older Adult CSS Plan: Service Extenders – Year 2

2007	
April, 2007	Develop plan for training new group of volunteer peer counselors
May, 2007	Recruit peer counselors
June, 2007	Conduct training program
June, 2007	Expand peer counseling programs

Older Adult CSS Plan: Service Extenders – Year 3

2008	
April	Develop training plan for new volunteer peer counselors
May	Recruit peer counselors
June	Conduct training program
	Expand peer counseling programs

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

OA-05: Training

1) Complete Exhibit 4 (as required under Section IV response).

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The CSS Training Program for older adult service providers will be dedicated to developing a transformative system by changing attitudes and knowledge regarding recovery, peer support and emerging best practices for culturally diverse older adults. In collaboration with the Transformation Design Team program described above, the CSS Training Program will provide education to professionals, peers, family members and community partners (e.g., primary healthcare providers, first responders, staff of senior centers) regarding values-driven and promising clinical services that support client-selected goals.

In order to accomplish the objective of developing integrated treatment models for older adults, the training program will involve direct training and cross-training of a variety of individuals including (but not limited to):

- Clients who will serve as peer counselor/peer bridgers
- Family members who will lead support and educational groups for other family members in the community
- Primary caregivers and other allied health professionals
- First responders
- Staff of community-based organizations such as senior centers, in-home support services and faith-based organizations
- Multidisciplinary mental health staff

The training topics and curriculum will be designed to address the multi-system characteristics of mental health services to older adults, with a bio-psycho-behavioral approach. Components include the following which are included in the CSS guidelines:

- Transformative training focused on changing attitudes in support of peer counseling/peer bridging programs (see section on Service Extenders)
- Education for primary care providers and other health providers to increase coordination and integration of mental health, primary care and other health services

Additional topics that support the values and priorities of the Mental Health Services Act include:

- Effective interventions; evidence-based and promising practices for culturally diverse populations
- Recovery models for older adults
- Integrated treatment of co-occurring disorders among older adult populations
- Challenges for transition age adults
- Employment and volunteerism for older adults
- Housing options for older adults
- Understanding of benefits; benefits establishment
- Stigma, ageism: influences on providers, clients and family
- Developmental/life cycle issues in aging
- Cultural Competence and Older Adult Mental Health Services
- Assessment methods/screening tools for ethnically and linguistically diverse groups

In addition to presentations on the above topics, it is recognized that there will be a need for ongoing consultation with the multidisciplinary teams developed as part of the Full Service Partnership and Field Capable Clinical Service Programs (see above). It is recommended that consultant hours be purchased to retain organizations and individuals with older adult expertise to provide clinical and system consultation to older adults system of care providers.

3) Describe any housing or employment services to be provided.

As noted above, specific training in the array of housing services available for older adults will be provided. Training on interventions designed to assist older adults to remain in preferred housing options will also be offered. Similarly, training in employment, volunteer and continuing education options for this population will be offered.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

It is essential that services to older adults under the Mental Health Services Act be consistent with the philosophy of wellness and recovery. This is a difficult concept for many, given the stigma that currently exists regarding both aging and mental illness. Therefore, identification of attitudes about older adults with mental illness will be a core component of all training offered. Provider staff will also be required to attend training

on the application of recovery concepts and strategies for older adults, including older adults with co-occurring substance abuse disorders.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Clients and family members of clients will be employed and will serve a variety of functions including working as service extenders in providing peer and family support, and as training group organizers to prepare the next generation of counselors and support givers.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Training will involve collaboration with experts in the field of mental illness and substance abuse. Many community partners will be included in the training efforts including older adult service providers, primary care providers, first responders, law, safety and code enforcement, public guardian, adult protective services, consumers, family members, caregivers, allied professionals, universities, professional organizations, training institutions, other county departments and the Department of Mental Health central and geographic operations.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Stakeholders have acted to ensure that every aspect of services included in the Community Supports and Services plan will be culturally competent and will meet the needs of culturally and linguistically diverse communities. All training topics presented as part of this series will include material related to cultural diversity and aging.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Training funded by the CSS plan will be sensitive to and address issues of sexual orientation and the differing psychologies of men and women. All training topics presented as part of this series will include material related to gender and aging.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

N/A

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Special training in recovery and wellness models for older adults is included in the CSS plan for older adults because it is critical to ensuring that services delivered are in line with the intent of the Mental Health Services Act. As noted above, understanding, accepting and implementing a recovery philosophy for older adults with mental illness is profoundly challenging for many individuals – including professionals currently working in this field. More specifically, for example, individuals who are entering the older adult system of care are expected to dramatically differ from earlier cohorts with regard to co-occurring substance abuse and other issues. It is essential that we dedicate training and consultation dollars to ensure that we are not just expanding traditional services delivered in traditional ways. Rather, training must help ensure that staff is capable of delivering excellent evidence-based services – embracing wellness and recovery as the platform for these efforts.

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
November	Develop training plan
	Identify providers to conduct training
December	Prepare training agreements

2006	
February	Program fully operational
Ongoing	Train staff
June	Conduct training program
	Expand peer counseling programs

2007	
July	Develop training plan, evaluate and modify based on training needs
August	Identify emerging evidence-based and best practices collaborative with
	Systems development
Ongoing	Conduct training

2008	
July	Develop training plan, evaluate and modify based on training needs
August/Ongoing	Identify emerging evidence-based and best practices collaborative with
	Systems development
Ongoing	Conduct training

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. This form will be required to be updated quarterly specifying actual population served. Additionally, a Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand. All progress reports are to be submitted to the DMH County Operations analyst assigned to the County within 30 days after the close of the quarter.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

CROSS-CUTTING SYSTEMS DEVELOPMENT INVESTMENTS

SN-01: Service Area Navigator Teams

1) Complete Exhibit 4.

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

One of the foundational premises of the Los Angeles County CSS plan is a belief that professionally delivered, public funded human services, by themselves, cannot deliver the outcomes we seek for people who struggle with mental health needs.

Funds from the MHSA will ultimately represent only 15-20% of the total LA DMH budget; the CSS plan represents less than 10% of the Department's budget. As promising as these new funds are, if we are committed to achieving the outcomes of the MHSA for all people in Los Angeles County who struggle with mental health issues, we must build structures that help people more quickly identify both the professional and community-based services and supports they need to advance their recovery and strengthen their capacity for wellness.

Service Area Navigator Teams will be a crucial structure to help people find the formal and informal supports they need. We will begin by establishing one Service Area Navigation team in each of the eight Service Areas. Team members and those who support them will:

- Engage with people who need services and their families to help them quickly identify currently available services, including supports and services tailored to the particular cultural, ethnic, age, and gender identity of those seeking them;
- Recruit community-based organizations and professional service providers to become part of an active and ever growing locally-based support network for people in the Service Area, including those most challenged by mental health issues;
- Follow-up with people with whom they have engaged to ensure that they have connected with support structures and received the help they need;
- Use information technology and other means to map and keep up to date about the current availability of services and supports in the Service Area;
- Engage in joint planning efforts with community partners, including community-based organizations, other County Departments, intradepartmental staff, schools, and health service programs, with the goal of increasing access to mental health

services and strengthening the network of human services available to clients of the mental health system;
- Collaborate with the Countywide Resource Management, Residential and Bridging Services, and Jail Transition and Linkage Services initiatives to further facilitate the return to the community of those individuals that have primarily been involved with psychiatric emergency/acute inpatient and institutional care; and
- Promote awareness of mental health issues, and the commitment to recovery, wellness, and self-help that lies at the heart of the Mental Health Services Act.

Members of Service Area Navigator Teams will regularly visit community organizations, emerging and well-established health and mental health programs, Law enforcement agencies, schools, courts, , residential facilities, NAMI chapters, self-help groups, client advocacy groups, and others. This model provides the beginning infrastructure to implement a system of care that is responsive to the local needs of communities, clients and families.

The Navigator teams in each SA will consist of a balance of community workers, people who have received services, family advocates, family members, and mental health professionals. While the precise design of these teams will vary by Service Area, reflecting each Area's particular local character and needs, each team will recruit members who together have substantial familiarity and expertise with all age groups, including the particular challenges facing those age groups and the distinct characteristics of the support networks for each.

3) Describe any housing or employment services to be provided.

The program will develop and maintain information on employment and housing services in the geographic area, and will actively recruit employers and housing providers to become an active part of the support network in the Service Area

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This program supports the CSS plan's overarching theme of a commitment to recovery and wellness. Beyond helping people find the supports and services they need to achieve and sustain wellness and recovery, the program will provide and/or make accessible regular training on recovery and wellness for the Navigator staff and community partners. Staff's commitment to these principles, as well as knowledge of

practical tools for putting this commitment into practice, will be regularly addressed during supervision, team meetings and performance evaluations. Of critical importance will be the increased use of self-help groups both for training staff and for the provision of recovery-focused support services. As previously noted, peer and family advocates will participate as members of the Navigation teams and in doing so will bring the richness of their experiences to the program.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Clients and family members will participate as members of the Navigator teams in each SA and will be responsible for ensuring that individuals and their families are informed of, have access to, and receive appropriate community based and client run services and supports, in addition to professional services. In addition, Navigation teams will have strong links with self-help groups and Wellness and Client Run Support Centers to enhance individuals' ability to live independently and to support recovery and resiliency.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

As detailed above, the Service Area Navigator teams will promote collaboration with community stakeholders in myriad ways, including: inviting stakeholders to participate on the Navigation teams; organizing and participating in various community planning, assessment, and engagement efforts; maintaining current information about available services and supports; and others. Key indicators of success will be the strength and flexibility of the provider network as evidenced by client retention in treatment and length of time between a request for service and the initiation of services.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The implementation of Service Area Navigator Teams will assist each of the Service Area service networks build its capacity to meet the specific needs of individuals in the various age and ethnic groups within the Service Area. Through the outreach and collaboration described above, the Navigator teams will develop competency in

understanding the culturally and linguistically diverse needs of their communities and the current resources available to meet those needs. Promoting the development of additional resources for unserved and underserved populations will be a key role of the Navigator teams.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Service Area Navigator Team members will reflect a diversity of experiences and skills with which to draw upon and ensure that services and supports identified to assist clients are sensitive to and responsive to their individual needs. This includes identifying services and supports that are sensitive to the differing needs based on gender and sexual orientation.

Also, as mentioned above, through the outreach and collaboration the Navigator teams will develop competency in understanding the diverse needs of their communities and the current resources available to meet those needs. Promoting the development of additional resources for unserved and underserved populations will also be a key role of the Navigator teams.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Currently out-of-county individuals who are residents of Los Angeles County, as well as their family members, at times struggle with arranging resources for their appropriate return to Los Angeles County. Navigation teams will be available to assist with referral and linkage to both out-of-county resources for individuals residing out-of-county and local resources for those Los Angeles County residents who are planning their return to this County.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
September	Designate DMH lead manager
October	Develop provider selection process
December	Select providers, subject to allocation of funding

2006	
January	Begin ongoing orientation efforts for DMH Countywide programs, SAACs, client and family groups and other stakeholder groups
	If CBO provider(s):
February	Complete contracting process
March	Begin implementation
	If DMH:
January	Obtain equipment & supplies
February	Obtain temporary space
March	Complete hiring and training process
	Begin implementation
March	Participation on SA Navigation Teams representing children, TAY and adults/older adults
March	Teams outreach to community agencies and other stakeholders within the Service Area
June	Full implementation
December	Assessment of program and implementation of program refinements

2007	
December	Ongoing implementation, program assessment, and program refinement

2008	
December	Ongoing implementation, program assessment, and program refinement

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

ACS-01a: Urgent Care Centers

1) Complete Exhibit 4.

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Urgent Care Centers (UCC) program is one of the four components of Alternative Crisis Services. This program, currently being explored and developed at several sites in the County—e.g., at Augustus F. Hawkins Mental Health Center and Olive View Medical Center—will provide intensive crisis services and integrated treatment for co-occurring disorders (COD) to individuals who would otherwise be brought to the Department of Health Services (DHS) County hospital Psychiatric Emergency Services (PES). These individuals are less likely to require psychiatric hospitalization or medical care, but are in need of medication management, stabilization and linkage to ongoing community-based services. Providing crisis intervention services to clients in a UCC with a focus on recovery and linkage to ongoing community-based mental health services will divert clients who would otherwise go to the PES and further aggravate overcrowded conditions in the PES. Clients evaluated in PES are most often placed on 72-hour detentions, often resulting in unnecessary and lengthy involuntary inpatient treatment. This alternative crisis service will promote the provision of mental health care and integrated treatment for COD in voluntary treatment settings that are recovery oriented.

Emphasis will be on highly specialized and intensive interventions, including rapid stabilization, outpatient detoxification, engagement with mental health and substance abuse specialists, and linkage to services within local communities. The length of patients' stay will be no more than 23 hours. Services include:

- Comprehensive psychiatric assessment, including substance abuse assessment
- Basic physical assessment, including assessment of symptoms related to substance abuse
- Referral to medical treatment when necessary
- Individualized mental health treatment and services
- Limited detoxification services
- Group interventions, e.g., AA meetings on the unit
- Engagement of clients with co-occurring substance abuse problems
- Crisis intervention, including family interventions when needed
- Medication management
- Housing assessment and referrals for emergency, transitional, permanent housing
- Referral to Full Service Partnership (FSP) programs

- Assessment of financial situations and initiation of benefits establishment process when indicated
- Referral to substance abuse programs, particularly those with capacity to admit persons with co-occurring mental illness
- Referral to employment, self-help, money management, and community resources for recreation and social interaction, etc.
- Referral and linkage to community mental health centers in clients' communities; linkage to clients' existing service providers
- Referral to Wellness Centers and Client Run Support programs

Surveys have shown that approximately 70 percent of clients in PES have substance abuse problems. The COD component of the UCC plan, through the DHS Alcohol and Drug Program Administration (ADPA), will provide much-needed on-site substance abuse assessment and referral capabilities and will begin to expand off-site capacity in community-based treatment and recovery programs for clients with COD who present in emergency settings. These services will include detoxification, stabilization/residential, intensive outpatient and transitional housing, along with other supportive services tailored to meet individual client needs. Clients will be provided with or assisted with accessing the following types of integrated treatment services:

Adolescents (ages 12 to 17) – A continuum of care, offering a full range of intensity and evidence-based approaches, needs to be expanded to address this population. Services should include the following:

- Licensed residential treatment services offering 24-hour stabilization, clinical case management, and therapeutic counseling; maximum treatment stay would be 60 days.
- Intensive certified integrated outpatient counseling services offering supportive placement, therapeutic individual, family and group counseling, and client supportive services tailored to meet individual client needs.
- Integrated outpatient services that are less intensive offering case management services and client supportive services tailored to meet individual client needs.
- Ongoing recovery support services that offer a broad array of programs supporting youth and their families, such as relapse prevention sessions, self-help and peer support group meetings and other strength-based activities promoting resiliency and achievement of recovery and wellness.

Adults (ages 18 and above, including transition age youth age 18 and over, adults, and older adults) – A full continuum of integrated treatment services will include detoxification, stabilization, intensive outpatient services with supportive housing, and ongoing recovery support. The following continuum of care, offering a full range of intensity and types of evidence-based integrated mental illness and substance abuse services is needed to comprehensively address this population's specific needs:

- Medically supported short-term residential detoxification services that provide stabilization and referral.

- Licensed residential services offering 24-hour clinical and integrated treatment services.
- Intensive certified outpatient counseling services offering clinical individual, family and group counseling services, case management and supportive housing assistance.
- Certified outpatient counseling services that are less intensive, offering client supportive services tailored to meet individual client needs.
- Ongoing recovery support services that offer a broad array of programs supporting persons in recovery and may follow completion of a structure treatment programs. Services may include relapse prevention sessions, self-help and peer support group meetings, and other activities promoting resiliency and achievement of recovery and wellness.

Expected outcomes of the UCC include the following:

- Reduced overcrowding in LA County PES as measured by reduced length of stay and reduced daily census
- Reduced number of adverse events in County hospital psychiatric emergency rooms
- Reduced hospitalization rates among identified intensive service recipients (high utilizers/ISRs) who are served by the UCC
- Reduced utilization of PES by identified high utilizers
- Increased community tenure (time spent living and working in the community) among people served by the UCC
- Change in substance abuse behaviors (uses less, attends meetings, classes, etc.)
- Enhancing and strengthening access, linkage and transition between crisis services and community based programs
- Planning, developing, and implementing programs that support the goal of increasing access to community-based mental health services, i.e. supportive residential and housing programs, and enrollment in FSP for persons exiting higher levels of care
- Identifying and addressing systemic barriers to providing coordinated mental health services with programs, providers, County, and State departments and agencies

3) Describe any housing or employment services to be provided.

Housing and employment services will not be provided directly, but through referral. Limited supportive housing for adult C0D clients requiring services will be available as a component of an intensive outpatient integrated treatment program. Integrated case management and employment services will also be available to clients as an integral component of treatment services.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The UCCs will ensure that program staff are selected for their commitment to a philosophy of recovery and, in addition, are trained in methodologies that will assist in crisis resolution and engaging individuals in ongoing services that will support them in recovery. The evaluation of staff understanding and implementation of these principles will be regularly addressed in supervision and team meetings. The program will ensure the involvement of clients and family members with recovery philosophies. In addition, this program advances the goals of recovery by improving the access from emergency services to on-site assessment, counseling and linkage to off-site integrated COD recovery-oriented services.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This program is based upon the UCC strategy currently under development as part of the Mental Health Services Act Planning process in Los Angeles County. This program will address the lack in the present system of a bridge for assisting clients in emergency settings in their transition into integrated treatment and support services.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Staffing patterns will include peer advocates, including those who qualify as substance abuse counselors. Peer counselors play a critical role in emergency services-based assessment, counseling and linkage. Most substance abuse treatment programs host self-help and peer recovery support group meetings at the facilities and encourage their clients to participate as part of their continuing recovery efforts. Many programs also host self-help and peer support group meetings for family members of persons in recovery. These group meetings are run entirely by persons in recovery or family members. Participation in these continuing care activities serves as an integral component of clients' recovery and relapse prevention plans.

The possibility of family education by the National Alliance for the Mentally Ill (NAMI), or similar groups will be explored.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

This program will collaborate with a number of other stakeholders to ensure that individuals are referred to and linked to necessary services and supports at the appropriate levels including Service Area Navigators, Residential and Bridging Services, FSP programs, Wellness Centers, client run supportive services, psychiatric emergency services, inpatient services, shelters, temporary, transitional and permanent housing. It will also collaborate with County and Fee-For-Service Hospitals, jails, MET/SMART, various police and sheriff stations and directly operated and contract mental health service providers. Long-standing collaborative relationships already exist between the ADPA and its contracted system of substance abuse treatment services and the mental health services system (DMH – Co-Occurring Disorders Programs), the child welfare services system (Department of Children and Family Services – Family Preservation and Reunification Networks), the juvenile justice and criminal justice systems (Superior Court and Probation Department – Juvenile Drug Court, Drug Court, Proposition 36), and the social welfare system (Department of Public Social Services – CalWORKs Supportive Services and County General Relief Program Substance Abuse Services). The proposed program will expand the capacity to assist persons with co-occurring disorders who are also likely to be involved with several of the systems described above.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

This program will support the CSS plan strategies for cultural and linguistic competency including the following strategies:

- Services will be provided to ethnic populations who are uninsured and uninsurable, consistent with the language and cultural needs of each community.
- Providers and community-based organizations that have ties to ethnic communities will be partnered with to ensure that these communities have full access to services.
- Planning in each community will include the involvement of clients that are reflective of each community's underserved ethnic groups.
- The program will recruit, hire, train and retain qualified bilingual-bicultural professionals, paraprofessionals, clients and families for each aspect of the program.

The ADPA's contracted providers operate a wide array of treatment services including programs that serve specific populations, such as adolescents, women, persons from

specific cultural/language groups, and gay/lesbian/bisexual/transgender. New UCC site-based staff will be appropriately drawn from these resources. Participating programs will be selected because of their demonstrated expertise in providing culturally and linguistically appropriate services for these specific populations.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

This program addresses issues related to gender and sexual orientation by relying on evidence-based assessment, intervention and support strategies. See Section 9 above.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

N/A

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
September	Designate DMH lead managers
November	Orient DMH Countywide programs, SAACs, client and family groups and other stakeholders

2006	
February	Complete contracting process
March	Program implementation if DMH
	If DMH:
January	Obtain equipment & supplies
February	Obtain temporary space
March	Complete hiring and training process
	Full implementation of first two UCCs
December	Full implementation of third UCC

2007	
December	Ongoing implementation, program assessment, and program refinement

2008	
December	Ongoing implementation, program assessment, and program refinement

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

ACS-01b: Countywide Resource Management

1) Complete Exhibit 4

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Countywide Resource Management Program is one of the four components of Alternative Crisis Services. The Countywide Resource Management Program, an administrative Department of Mental Health (DMH) program, will provide overall administrative, clinical, integrative, and fiscal management functions for the Department's acute inpatient (uninsured persons), and adult/older adult long-term institutional, crisis residential, intensive residential and supportive residential (IMD step-down) resources, with daily capacity for over 1200 persons. The Department's Interim Funding Program and the proposed Residential and Bridging Services, and Jail Transition and Linkage Services will also be under the direction of this program.

By centralizing the management of these Countywide resources, this program will be vital to the success of the CSS plan, enhancing individuals' ability to avoid or reduce lengths of stay in involuntary treatment and institutional settings. Staffing for this initiative will consist of a Mental Health Clinical District Chief and a Mental Health Analyst.

The Countywide Resource Management Program's responsibilities will include:

- Being responsible for overall administrative, clinical, integrative and fiscal aspects of all resources within the program;
- Coordinating functions to maximize client flow between higher levels of care and community-based mental health services and supports;
- Planning and implementing programs on an ongoing basis that promote transition of individuals residing in institutional care to community-based programs that promote recovery and reduce rates of hospitalization, incarceration, and placement in Institutions for Mental Disease (IMD);
- Negotiating and managing Countywide, multi-million dollar contracts with hospitals, long-term care and community providers;
- Directing and coordinating program reviews and evaluation of outcomes to ensure that services provided address the unique needs of clients served, including those with co-occurring behavioral disorders, and that they are in compliance with the terms of the contracts and County, State, and Federal mandated standards; and
- Interfacing with other County, State, and Federal departments/agencies, the Mental Health Commission, Service Area (SA) administrations and Advisory

Committees, NAMI, and other stakeholders regarding program resources and coordination in order to ensure appropriate utilization and coordination of resources.

Current fragmentation of mental health service delivery contributes to over-reliance on costly crisis and inpatient resources, as well as unnecessary incarcerations. This program will provide enhanced coordination, linkage and integration of inpatient and residential services throughout the system thereby enhancing the goals of the MHSA by reducing re-hospitalization, incarceration and the need for long-term institutional care, while increasing the potential for community living and recovery.

3) Describe any housing or employment services to be provided.

N/A

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This program will ensure that the program staff of all Countywide resources under its management are trained in recovery principles and that staff's understanding and implementation of these principles are regularly addressed in supervision and team meetings. Peer advocates/bridgers currently lead Project Return and bridging groups in the IMDs to help IMD residents prepare for discharge and establish connections in the communities in which they will be living. This program will ensure that the involvement of clients and family members will continue to be increased in similar approaches in all programs under its management.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

N/A

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The program will collaborate through regular and "as needed" meetings with County and private hospitals, County departments/programs, community providers, State and Federal agencies, including the State Department of Mental Health, law enforcement, and family and consumer organizations to ensure better coordination of services. The program will improve system services and outcomes for individuals by:

- Enhancing and strengthening access, linkage and transition between involuntary and long-term settings and community based programs
- Planning, developing, and implementing programs that support the goal of increasing access to community-based mental health services, i.e. supportive residential and housing programs, and enrollment in FSPP for persons exiting higher levels of care
- Identifying and addressing systemic barriers to providing coordinated mental health services with programs, providers, County, and State departments/agencies

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

This administrative program will act to ensure that the programs under its management support the CSS plan strategies for cultural and linguistic competency including the following CSS strategies:

- Dedicated funding will be allocated to ethnic populations who are uninsured and uninsurable, consistent with the language and cultural needs of each community. Benchmarks are being established and will be monitored to ensure that programs funded through MHSA CSS dollars achieve the requisite level of service to underserved ethnic minority populations.
- The number of community-based organizations that have ties to ethnic communities will be expanded and partnerships with providers that have such community ties will be strengthened.
- Planning in each community will include the involvement of consumers that are reflective of each community's underserved ethnic groups.
- The Department will develop and implement programs that increase the system's capacity to recruit, hire, train and retain qualified bilingual-bicultural professionals, paraprofessionals, consumers and families for each aspect of the CSS plan.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

This administrative program will ensure that all programs under its management address issues related to gender and sexual orientation by relying on evidence-based assessment, intervention and support strategies.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The program will monitor the treatment/progress of individuals residing in out-of-county placements such as State hospitals and IMDs. It will provide access to in-county placement, transition assistance and linkage to community-based programs at discharge.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
October	Prepare request to County Department of Human Resources (DHR) for allocation of items
November	Develop policy and procedures
	Obtain DHR preliminary review of item allocation request and make suggested revisions
	Identify temporary space for program

2006	
January	Obtain DHR approval of requested items
	Order Equipment, Furniture, Office Supplies
	Order Telephones, Computers, Network Access
	Order Cell Phones, Pagers, Calling Cards
	Install Office Equipment and Computers
February	Hire/appoint and train staff
	Select permanent site location
	Full Implementation
March	Obtain permanent site, prepare space request, design space layout
May	Renovate space, move program
December	Develop and administer an evaluation tool for effectiveness of resource management

2007	
June	Make adjustments to program operations based on program evaluation
December	Ongoing implementation

2008	
December	Ongoing assessment of the mix and utilization of the various levels of residential care under this program's management; shifting of resources to support increase in supported independent living situations, as indicated

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

ACS-01c: Residential and Bridging Services

1) Complete Exhibit 4.

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Residential and Bridging Services is one of the four components of Alternative Crisis Services. The Residential and Bridging Services will provide DMH program liaisons and peer advocates/bridgers to assist in the coordination of psychiatric services and supports for TAY, adults and older adults being discharged from County hospital psychiatric emergency services and inpatient units, County contracted private acute inpatient beds for uninsured individuals, UCCs, IMDs, crisis residential, intensive residential, and supportive residential (IMD step-down) facilities. The program will ensure linkage of these clients upon discharge, with appropriate levels and types of mental heath and supportive services, residential, substance abuse, and other specialized programs. The program will promote the expectation that clients must be successfully reintegrated into their communities upon discharge and that all care providers must participate in client transitions. The Countywide Resource Management Program will manage and coordinate the Residential and Bridging Services.

This program will utilize MHSA funding and the following strategies:

- In inpatient settings staff will identify those Intensive Service Recipients (ISR) enrolled in FSP/AB 2034/Assertive Community Treatment (ACT) programs or served by other outpatient service providers and link these providers to the hospital treatment teams for the purpose of coordinated treatment and discharge planning.
- The liaisons and peer advocates will collaborate with inpatient, emergency services, and residential treatment teams, to assist in developing after care plans for those clients identified with intensive and complicated service needs that are not already in FSP/AB 2034 or ACT programs.
- The program will coordinate discharge planning with Service Area Navigators to ensure that individuals have access to appropriate resources in their geographical areas.
- Liaisons and advocates will work collaboratively with community providers to facilitate linkage to community-based resources. This includes coordination with substance abuse programs, mental health clinics, residential providers, FSPs, self-help groups and bridging services. The program will ensure continuity of care and consumer support during the discharge process.

- Staff will assist in benefit establishment activities to ensure applications for benefits are initiated in a timely manner. This will include advocacy and identification of system barriers that prevent the establishment of benefits.
- The program will identify system barriers, including social and financial barriers, to successful re-integration of individuals into their communities and work with other departmental programs and community agencies to resolve these barriers.
- The program will employ a recovery approach toward treatment with a strength-based focus that empowers clients to develop their goals toward community re-integration, skills to become self-sufficient and the capacity to increase current levels of community functioning.
- Peer support and family involvement will be an important aspect of the program promoting community re-integration. For example, the program will employ peer advocates and there will be client-run self-help groups providing support and peer bridging.
- The program will support the outcomes identified in the CSS plan.

3) Describe any housing or employment services to be provided.

This program will not directly provide housing or employment services but, as described above, will provide coordination and linkage to programs that will address housing and employment.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This program supports the CSS plan's commitment to recovery and wellness. The program will provide initial and ongoing training on recovery and wellness for acute inpatient, State hospital, IMD, and crisis, intensive and supportive residential staff. Education and training about recovery in these settings will promote recovery, not just as way of helping some individuals do better, but also as a means of engaging those who do not fit well in the current mental health system, i.e., individuals with co-occurring disorders, homelessness, forensic histories, and non-compliance. System transformation will not be successful without training in these settings as well as the community at large.

The program will utilize community self-help and peer advocacy resources as well as DMH peer advocates to transition individuals from the programs under its management to FSPs and other community-based services. This program will directly, and through collaboration with self-help groups, increase the levels of client/family participation in the mental health service delivery system, enhance discharge planning and linkage to community-based alternatives to institutionalization, and promote recovery and wellness.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This program is based on an existing strategy utilized primarily in IMDs and the DHS PES and inpatient units whereby DMH staff assist those providers with discharge planning. The proposed program will build upon this experience by assisting with discharge planning and linkage to community-based resources for all services under the management of the Countywide Resource Management Service. It should be noted that the quantity and variety of these Countywide Resources have increased greatly over the past year and will continue to do so under the MHSA. For example, in recent months the Department has doubled its number of contracted private inpatient beds for uninsured clients of all ages. In addition a Psychiatric Diversion Program which funds up to 16 additional inpatient beds per day for the uninsured to divert them from the DHS system has been implemented, and new intensive and supportive residential facilities are included in this CSS plan. This initiative will provide a group of professional and peer advocate staff that will function within and across all Countywide Resources, greatly enhancing the Department's ability to support individuals' progress toward recovery and independent community living.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Peer advocates and family members will participate as part of this program with the following responsibilities:

- Provide self-help support groups (peers advocates and families) within facilities to support individuals transitioning to community living
- Facilitate client participation in developing service plans and goals
- Serve as members of a multidisciplinary team to provide education, support, advocacy, and information regarding clients' progress in achieving their goals (peer advocates)
- Assist clients in developing community living skills and utilizing community resources
- Provide education and advocacy about recovery and wellness to clients, families, and providers

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

This program will collaborate with a number of other stakeholders to ensure that individuals receive services that are specific to their needs. The program will collaborate with County and private hospitals, Service Area Navigators, institutional providers, FSP programs, community peer support programs, mental health clinics, psychiatric emergency outreach teams, alcohol and drug programs, residential and other community providers to ensure coordination of services that support wellness and recovery.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Strategies to be used for this program to promote cultural and linguistic competency include the following:

- Benchmarks will be established and monitored to ensure that this program achieves the requisite level of service to underserved ethnic minority populations
- Collaboration with community-based organizations that have ties to ethnic communities will be expanded and strengthened
- Culturally and linguistically appropriate strategies, policies and procedures will be developed to ensure access to culturally appropriate services for unserved, underserved and inappropriately served ethnic populations.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

This program will be sensitive to and address issues of sexual orientation and the differing psychologies of men and women by relying on evidence-based assessment, intervention and support strategies. Program staff will be trained in these strategies and provided ongoing supervision on their implementation.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The program will provide discharge planning and linkage to County community mental health services and supports for individuals residing in out-of-county placement, such as State hospitals or IMDs.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2005	
October	Prepare request to County Department of Human Resources (DHR) for allocation of items
November	Develop policy and procedures
	Obtain DHR preliminary review of item allocation request and make suggested revisions
	Identify temporary space for program

2006	
January	Obtain DHR approval of permanent items
	Order Necessary Equipment, Furniture, Office Supplies
	Order Necessary Telephones, Computers, Network Access
	Install necessary Office Equipment and Computers
	Orient Countywide programs and other stakeholders to this program
	Hire/appoint and train staff
February	Select permanent site location to be co-located with Countywide Resource Management
	Full Implementation
March	Obtain permanent site, prepare space request, design space layout
May	Renovate space, move program
December	Develop and administer an evaluation tool for effectiveness of residential liaisons/bridgers

2007	
June	Make adjustments to program operations based on program evaluation
December	Ongoing implementation

2008	
December	Assist with ongoing assessment of the utilization of the various levels of residential care; shifting of resources to support increase in supported independent living situations, as indicated

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

ACS-01d: Enriched Residential Services

1) Complete Exhibit 4.

The Exhibit 4 template has been completed for each Los Angeles County work plan recommended for CSS funding. Each work plan addresses Questions 1) a) - d). Questions 2) – 13) are answered for each program in the following narrative.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Enriched Residential Program is one of the four components of Alternative Crisis Services. The Enriched Residential Program will be a secure 48-bed augmented, licensed Adult Residential Facility (ARF) that will serve DMH clients, 18 to 64 years of age, who are ready for discharge from acute psychiatric inpatient units, Crisis Residential facilities or Institutions for Mental Disease (IMD). This program, provided by a DMH contractor, will increase the Department's community-based intensive residential resources that are focused on breaking the cycle of costly emergency and inpatient care and promoting successful community re-integration.

The program will target those individuals in higher levels of care who require intensive mental health supportive services to transition to stable community placement and prepare for more independent community living.

- The anticipated length of stay will be two to six months.
- The program will have 24/7 capacity for emergencies and specialized programming.
- Staffing will include licensed mental health professionals, mental health workers, certified drug and alcohol counselors, and family and peer advocates.
- As clients progress, they will be able to transition into FSPs and independent living and participate in vocational activities in the community.
- The program will provide individual and group treatment, medication support, crisis intervention, case management, and vocational rehabilitation services.
- Peer support and family involvement will be a primary focus of the program promoting community re-integration before discharge from the program. For example, there will be Project Return, a client-run self-help group with peer bridgers, and DMH peer support advocates/bridgers.
- MHSA, Medi-Cal, Medicare, and any other available third party revenues will support the program/
- Outcomes will be consistent with those outlined in the CSS plan.

3) Describe any housing or employment services to be provided.

This program will provide housing and the opportunity for residents to participate in the provider's vocational training program. Prior to discharge, residents will be linked to FSPs or other mental health providers that will address housing and employment opportunities on an ongoing basis.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

This program supports the CSS plan's commitment to recovery and wellness as detailed in Section 2 of the plan. The program will provide initial and ongoing training on recovery and wellness for its program participants, their families, peer advocates, and paraprofessional/professional staff.

The program will utilize community self-help and peer advocacy resources as well as County peer advocates identified in the Residential and Bridging Services component to transition individuals in the program to FSPs or other mental health services and permanent housing. This program will directly, and through collaboration with self-help groups, increase the levels of client/family participation in the mental health service delivery system, increase the array of community-based alternatives to institutionalization, and promote recovery and wellness.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

This will be a new program in Fiscal Year (FY) 2006-2007 that will be based on experience gained from several pilots/models of augmented residential programs which the Department will be implementing in FY 2005-2006.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Peer advocates will serve as members of the Countywide Resource Management's multi-disciplinary team that monitors and promotes quality of care within its programs. Peer advocates will also:

- Provide self-help support groups within the facility prior to discharge to support individuals' transition to community living.
- Facilitate client participation in developing service plans and goals.
- Provide members of the team with information regarding clients' progress in achieving their goals.
- Assist clients in developing community living skills and utilizing community resources.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

This program will collaborate with a variety of stakeholders to ensure that individuals receive services that are specific to their needs, including Countywide Resource Management, Service Area Navigators, institutional providers, community peer support programs, mental health clinics, and others to ensure coordination of services that support wellness and recovery. There will also be extensive collaboration with other stakeholders such as, Alcohol and Drug Program providers and the County's Asian-Pacific Alliance to meet specific needs of individuals residing at the program, and with FSPs as individuals move towards recovery and transition to independent living.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Mental health services will be provided within a relevant and meaningful cultural, gender-sensitive, and age appropriate context for the individuals being served.

Recovery and rehabilitation are most likely to occur when staff have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers, their families, and communities. Training will be provided to staff to promote cultural awareness and sensitivity, including treatment based on knowledge and skills derived from culturally competent interventions and models of care, i.e., cultural norms, values, and critical life experiences.

The program will have the capacity to provide services that are linguistically diverse through the inclusion of ethnically minority staff. The Department intends to explore the possibility of the possibility of developing an American Sign Language (ASL) program at the facility for hearing-impaired individuals hearing-impaired individuals currently in an out-of-county IMD.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Mental health services will be provided within a relevant and meaningful gender-sensitive and age appropriate context for the individuals being served. Training will be provided to staff to promote awareness and sensitivity to genders, sexual orientation and the differing psychologies and needs of women and men.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

The program will provide services for clients who meet admission criteria from State Hospitals outside of Los Angeles County, as well as those currently residing in an out-of-county IMD with a special program for hearing impaired clients. The program will also be available to out-of-county forensic clients currently in State Hospitals after their legal status has changed to LPS conservatorship and after stabilization in County IMDs.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

2006	
July	Amend contract
	Review and approve program guidelines, policy and procedures; ensure that all program elements are in place and in compliance with local and State requirements
	Ongoing implementation
	Initiation of client run groups at the facility
December	Program quality of care review, identification of any areas requiring correction and development of corrective action plan
	Program fully operational

2007	
June	Assessment of program (lengths of stay, linkages, client outcomes, participation of peers and families in service delivery, cultural competency) and implementation of program refinements
	Development of American Sign Language (ASL) program
December	Ongoing implementation, program assessment, and program refinement

2008	
December	Development of capacity to serve former forensic clients
	Ongoing implementation, program assessment, and program refinement

1

4) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan. Budgets and Staffing Detail Worksheets and Budget Narratives are required for each program work plan for which funds are being requested.

Exhibit 5 contains Budget and Staffing Detail Worksheets for each program for which Los Angeles County is requesting funding.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.

Exhibit 6 contains estimates for the number of individuals expected to receive services through this and all other programs for which Los Angeles County is requesting funding.

ONE-TIME FUNDING INVESTMENTS

Delegates reached consensus on six priority investments for the projected one-time that may be available to Los Angeles County. We understand that all efforts funded through one-time funds must be completed by June 30, 2006. The priority investments include:

- A Housing Trust Fund;
- One-time Training and Workforce Development Initiatives;
- Outreach and Engagement investments;
- Planning and Outcomes infrastructure investments;
- System infrastructure; and
- A Prudent Reserve.

We believe all of these investments are specifically allowed under the guidelines for one-time funds as outlined in DMH Letter No. 05-06, dated September 2, 2005.

OT-01: Housing Trust Fund
Delegates recommend allocating $11.6 million of one-time funds to help capitalize a Housing Trust Fund to support the development of new permanent supportive housing for individuals with psychiatric disabilities, particularly those individuals who are homeless or are living in Residential Care Facilities, Institutions for Mental Disease and other settings such as Sober or Collaborative Living facilities.

The MHSA funds dedicated to the Trust Fund account will be used to:

- Leverage other local, state, and federal financial resources for developing permanent affordable supportive housing for all age groups, including children, youth and families, transition age youth, adults, and older adults.
- Provide on-going rental subsidies and the on-site supportive services necessary for special needs housing developers to leverage millions of dollars in capital funds. Long-term commitments for project-based vouchers or other types of rental subsidies are necessary for special needs housing developers to obtain long-term financing for the capital costs of new projects. Historically, federally sponsored Section 8 vouchers have served this purpose. However, in recent years there has been a dramatic decrease in the availability of Section 8 tenant and project-based vouchers, a trend that is expected to continue. The Housing Trust Fund will fill a crucial gap in commitments for rental subsidies and supportive services required for the development of permanent, affordable and safe supportive housing.
- Provide emergency housing for emancipated homeless youth during the outreach and engagement process
- Fund consultants to assist in planning strategies to minimize any neighborhood opposition to special needs housing in their neighborhoods.

The Department, in conjunction with a Housing Trust Fund Advisory Board (HTFAB), will establish specific administrative and program guidelines outlining the purposes of

the Housing Trust Fund, the targeted beneficiaries, basic eligibility requirements for receiving funds, the funding process, and the mechanism for overseeing the Trust Fund operations. The Housing Trust Fund Advisory Board will include representatives from County and local governments, and other appropriate stakeholders. The Board will include significant representation from clients and family members. Additionally, the Department will encourage a broad range of consumer input on the HTFAB. Special attention will be given to engage homeless and formerly homeless individuals at different points in their recovery and from different types of housing initiatives, age groups, and minority populations.

Of the recommended $11.6 million for this housing initiative, delegates recommend using $100,000 of these resources to fund a planning and design initiative. The purpose of this planning and design work, called the NIMBY (Not in My Backyard) initiative, is to develop an on-going approach for responding to local concerns and resistance to the siting of permanent supportive housing for people with severe and persistent mental illness.

OT-02: Workforce Training and Development
Meeting the aggressive implementation timelines outlined in the Los Angeles County CSS plan will require a workforce committed to recovery, grounded in principles of cultural sensitivity and competency, and dedicated to achieving positive outcomes for those most severely affected by mental health issues. The purpose of this one-time funding proposal is to jump start efforts in Los Angeles County to strengthen its mental health workforce in ways that will insure the success of the Mental Health Services Act.

The three target groups for this proposal include:

- People who are not yet working in the mental health system who are committed to getting a job working somewhere in the system
- People who are currently working in the mental health system or in partnering organizations, agencies, and departments
- People who are in degree-granting programs for whom there is a documented urgent need

1. **Target group:** People who are not yet working in the mental health system

   a. This group:
      - Includes people without bachelor degrees as well as people with bachelors degrees
      - Will include substantial numbers of people who receive services, family members, including caregivers of young children, and members from underserved populations, including ethnic and racial groups.

   b. The outcomes sought for this group as a result of this proposal include:
      - A job in the mental health system providing effective mental health services, including but not limited to jobs with:

- The Department of Mental Health
- Community-based organizations providing mental health services
- Contract providers
- Partner departments and organizations

- Increased understanding and commitment to the concepts of wellness, recovery, and resiliency as part of their work

c. The basic design for this population
   - An intensive training and orientation program (or programs) that would include at least 4 basic components:
     - Classes to introduce participants to the essential components of the mental health system, and the essential elements of mental health services grounded in a commitment to wellness, recovery, and resiliency.
     - Experiential learning opportunities for participants to experience first-hand one or more aspects of the mental health system
     - Peer and mentoring support to help participants make sense of and learn from their experiences
     - Support for securing a job at the conclusion of the program

   - The exact design of this approach will be determined over the next several months. We will research existing models and programs to insure that we can meet the time constraints associated with the one-time funds.

d. Estimated budget: $2.5 million

2. **Target group:** People who are currently working in the mental health system or in partnering organizations, agencies, and departments

   a. This group:
      - Includes current staff for LA DMH
      - Includes current staff for partnering organizations, agencies, and departments, including but not limited to:
        - Law enforcement personnel
        - Staff from other County departments, including Probation, Health Services, Department of Children and Family Services, Department of Public Social Services, and others
        - Staff from community agencies, organizations, and contract providers
        - Community based workers—e.g., existing Promotoras and others
      - Includes people with no degrees and practitioners with advanced degrees
      - Will include substantial numbers of people who receive services, family members, including caregivers of young children, and members from underserved populations, including ethnic and racial groups
      - Will prioritize people who are essential in the first phases of implementation for the Community Services and Supports plan

b. Outcomes sought for this group as a result of this proposal
   - Increased understanding and commitment to the concepts of wellness, recovery, and resiliency as part of their work, including their responsibilities implementing parts of the Community Services and Supports plan
   - Recruit people from this group who are willing to sponsor experiential placements and jobs for people from the first target group

c. The basic design for this population
   - A consortium of stakeholders, including people who receive services, family members, including caregivers of young children, ethnic and racial groups, DMH representatives, and representatives from partnering organizations, agencies, and departments, will oversee:
     - The selection and recruitment of people to participate in the various programs and training modules.
     - The identification and selection of programs and training modules to provide the training;
     - The monitoring of learning objectives.

   - A group of consultants will be hired to:
     - Identify available programs and training modules;
     - Match priority programs and training modules to the projected participants' needs and develop reasonable learning objectives for the different groups.

   - Various programs and training modules will be identified that can introduce a diverse array of participants to:
     - The fundamental concepts of wellness, recovery, and resiliency;
     - Different cultural conceptions of mental health;
     - Other skills and orientations needed to help effectively implement the Community Services and Support plan.

d. Estimated budget: $5 million

3. **Target group:** People who are in degree-granting programs for whom there is a documented urgent need

a. The group refined
   - People in the second year of Social Work school, Marriage and Family Therapy programs, Psychiatric Technician programs who are committed to working in the mental health system
   - People in the first year of these programs who are committed to working in the mental health system
   - People in BA programs committed to working in the mental health system
   - People in psychology degree granting programs who are fluent in one of the 11 threshold languages (other than English) and who are committed to providing mental health services to people in communities who speak that threshold language

b. Outcomes sought for this group as a result of this proposal
   - Increased understanding and commitment to the concepts of wellness, recovery, and resiliency as part of their work
   - Commitments from students who will graduate within the next year (ideal) or the next two years to provide high need services and supports in the mental health system in Los Angeles County

c. The basic design for this population
   - Agreements will be developed between the Department and several schools to provide support to students in exchange for a commitment to work for one or more years in areas of critical need in the mental health system.

   - Some examples of these programs include:
     - Social Work: The social training proposal addresses the Department's immediate need to increase the number of bilingual and multi-cultural social workers throughout the mental health delivery system in order to address the needs of underrepresented groups. Students enrolled in graduate programs in Los Angeles with field placements at DMH directly operated and contract agencies would receive stipends. Funding for stipends to support trainees with MHSA one-time funds would be converted to ongoing funding through CALSWEC once that plan is finalized by the state. Estimated budget: $1.2 million

     - Marriage and Family: The Marriage and Family Therapy proposal addresses the Department's immediate need to increase the number of bilingual and multicultural mental health providers with an emphasis in working with families. Students enrolled in graduate programs in area universities would be granted stipends for field placements in DMH directly operated or contract agencies. Estimated budget: $900,000

     - Psychiatric Technician: To further address the Department's need for bilingual and multicultural mental health providers, DMH will develop partnerships with Mt. San Antonio and Hacienda La Puente Community Colleges to implement training opportunities for students enrolled in psychiatric technician training programs. Estimate budget: $168,000

     - Psychology: Conversations will begin soon with programs to explore how to identify and provide support to psychologists who are fluent in one of the 11 threshold languages other than English and who are committed to providing mental health services to people in communities who speak that threshold language.

d. Estimated budget: $2.5 million

4. Total projected budget: $10 million

OT-03: Outreach and Engagement investments
See discussion under Exhibit 5, Sub--tab 21.

OT-04: Planning and Outcomes infrastructure
See discussion under Exhibit 5, Sub--tab 22.

OT-05: System infrastructure
LA DMH is requesting $8,250,000 in one-time funds for infrastructure essential in supporting the CSS initiatives in the areas of information technology, transportation, critical clinic refurbishments, the purchase of modular buildings, and flexible funding to supplement infrastructure as needed. The following details the projected expenditures:

1. Information Technology Systems $3,177,000

    a. Integrated Behavioral Health Information System (IBHIS): To effectively execute the intent of the MHSA, the Department must select and implement an IBHIS that will meet the needs of both contracted and directly operated providers.

    b. Data Warehouse: It will be necessary to interface the IBHIS with other information systems to provide all of the data and functionality that DMH and its partners need to deliver services, manage operations, and complete required reports. This data would come together in a data warehouse so it can be managed and made available as appropriate.

    c. Technology Infrastructure (Two Interface Engine Servers, Additional Networked Storage, and Providers' Required Upgrade for Computer Hardware): These components are critical to data storage capacity and computer hardware needs to better position service delivery staff to handle the MHSA implementation.

2. Vehicles $1,279,000

Vehicles will be needed to meet the transportation needs of clients enrolled in Full Service Partnership programs at both contracted and directly operated clinics. The funding will purchase 73 vehicles and serve the needs of over 4,000 clients.

3. Building and Refurbishments $3,500,000

Critical refurbishments will be made to clinics, both contract and directly operated programs, in order to provide better service and an improved environment to clients. In addition, to house our Olive View Alternative Crisis Services, a modular building will be purchased.

4. Flexible Supplemental Funding $ 294,000

To be allocated based on need, between additional computer hardware upgrades, vehicles, and critical clinic refurbishments using a formula based on Full Service Partnership Clients.

OT-06: A Prudent Reserve

The Mental Health Services Act legislation specifically calls for the establishment of a Prudent Reserve to help counties weather year-to-year fluctuations in funding for the MHSA. DMH Letter No. 05-06, dated September 2, 2005, sets an ultimate target for this reserve at one-half of a County's first year CSS allocation. For Los Angeles County, that would equal $44,896,400. While we have initially recommended $9,046,400 be invested in this reserve fund, to the extent we do not meet our other one-time funding spending targets, we expect to be able to move the unspent one-time funds into the reserve fund to insure that these funds are not lost to Los Angeles County.